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No.

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1994

FLOYD T. BRYAN, and
FLOYD T. BRYAN, M.D., P.A., Petitioners,

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Jennifer S. Carroll
Metzger, Sonneborn & Rutter, P.A.
1545 Centrepark Drive North
West Palm Beach, Florida 33401-7414
(407) 684-2000
Counsel of Record

George H. Moss
Moss, Henderson, Van Gaasbeck,
Blanton & Koval
Post Office Box 3406
Vero Beach, Florida 32964-3406

January 29, 1995

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QUESTIONS PRESENTED

1. Whether a physician's evidence of "bad faith" during the peer review process is *relevant* to the determination of whether a defendant hospital is entitled to immunity under the Health Care Quality Improvement Act. 42 U.S.C.A. §§ 11101-11152.

2. In view of the HCQIA "presumption," is a defendant's compliance with HCQIA's immunity standards a question for the jury or the trial judge when there exist genuine issues of material fact, or does the HCQIA presumption create an "unusual" summary judgment standard?

3. Is a physician denied due process under the Health Care Quality Improvement Act if direct economic competitors of that physician actively participated in the peer review proceedings?

4. Whether evidence demonstrating that (a) direct economic competitors actively participated in the peer review process; (b) the peer review proceedings were conducted in bad faith; and (c) the physician's termination was motivated by improper economic reasons is sufficient to rebut the HCQIA presumption as a matter of law.

5. Does the reviewing court exceed the scope of appellate review in an HCQIA case by reweighing the trial judge's findings of fact without applying the "clearly erroneous" standard of review articulated by this court in Amadeo v. Zant, 486 U.S. 214 (1988)?

LIST OF PARTIES

The parties to the present appeal are the petitioners (collectively referred to as "petitioner"), Floyd T. Bryan and Floyd T. Bryan, M.D., P.A., and the respondent, James E. Holmes Regional Medical Center, a/k/a Holmes Regional Medical Center, Inc. The individuals listed in the style of the lower court's opinion were not involved in the appellate proceedings.

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OPINIONS BELOW

The opinion of the Court of Appeals for the Eleventh Circuit is reported at 33 F.3d 1318, and is reprinted in the appendix hereto at A.1-52.

The jury verdict in favor of petitioner, the final judgment thereon, and the trial court's orders on respondent's motions for summary judgment and new trial/judgment as a matter of law are not reported decisions, but are reprinted in the appendix, *infra.* at A.53-81; 90-93.

JURISDICTION

Invoking federal jurisdiction under 28 U.S.C. §§ 1337 and 1331, the petitioner brought suit in the United States District Court, Middle District of Florida against respondent for the wrongful termination of his staff privileges. On June 17, 1992, a jury rendered a verdict in favor of petitioner for $4.2 million, finding that defendant breached its bylaws and violated state and federal antitrust laws. (A.92-93) A Final Judgment was entered on June 22, 1992. (A.90-91)

Respondent appealed to the Eleventh Circuit Court of Appeals on September 23, 1992. On October 4, 1994, the Eleventh Circuit rendered an opinion reversing the jury verdict. Petitioner filed a Suggestion for Rehearing En Banc/Petition for Rehearing on October 27, 1994, which was denied on December 9, 1994. (A.87-89)

The jurisdiction of this Court to review the judgment of the Eleventh Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTES, RULES AND CONSTITUTIONAL PROVISIONS

1. Health Care Quality Improvement Act, 42 U.S.C.A. §§ 11111(a)(1) and 11112(a), (b):

42 U.S.C.A. § 11111(a)(1):

> **§ 11111. Professional review.**
> **(a) In general**
> **(1) Limitation on damages for professional review actions**
> If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section --
> (A) the professional review body,
> (B) any person acting as a member or staff to the body;
> (C) any person under a contract of other formal agreement with the body, and
> (D) any person who participates with or assists the body with respect to the action,
>
> shall not be liable for damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action....

42 U.S.C.A. § 11112(a):

> **§ 11112. Standards for professional review actions**
> **(a) In general**
> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken --
>
> (1) in the reasonable belief that the

> action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances;
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

42 U.S.C.A. § 11112(b):

This lengthy section is set forth in the Appendix to this petition at A.333-335.

2. Federal Rule of Civil Procedure 56(c):

> **Rule 56. Summary Judgment.**
>
> * * *
>
> **(c) Motion and Proceedings Thereon**. The motion shall be served at least 10 days before the time fixed for the hearing. The adverse party prior to the day of hearing may serve opposing affidavits. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is

entitled to a judgment as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

3. Federal Rule of Civil Procedure 52(a):

Rule 52. Findings by the Court; Judgment on Partial Findings.

(a) Effect. In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon, and judgment shall be entered pursuant to Rule 58; and in granting or refusing interlocutory injunctions the court shall similarly set forth the findings of fact and conclusions of law which constitute the grounds of its action. Requests for findings are not necessary for purposes of review. Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses. The findings of a master, to the extent that the court adopts them, shall be considered as the findings of the court. It will be sufficient if the findings of fact and conclusions of law are stated orally and recorded in open court following the close of the evidence or appear in an opinion or memorandum of decision filed by the court. Findings of fact and conclusions of law are unnecessary on decisions of motions under Rule 12 or 56 or any other motion except as provided in subdivision (c) of this rule.

4. **United States Constitution Amendment VII:**

In Suits at common law, where the value of controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, then according to the rules of the common law.

5. **United States Constitution Amendment V:**

No persons shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATEMENT OF THE CASE

This Petition for Certiorari arises out of an Eleventh Circuit Court of Appeal's opinion reversing a $4.2 million jury verdict in favor of petitioner on the ground that the hospital was entitled to immunity as a matter of law under the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C.A. §§ 11101-11152.[1]

The court of appeals ruled that (1) evidence that the peer review was conducted in bad faith was *"immaterial"* to the issue of a defendant's entitlement to the HCQIA immunity, and (2) the question of a defendant's compliance with the peer review standards is never a question for the jury, even when there exist genuine issues of material fact. (A.40,45) The facts which are pertinent to this Court's review of the legal issues raised in this petition are set forth as follows.

On December 5, 1990, Floyd T. Bryan, M.D. brought suit against defendants, Holmes Regional Medical Center (HRMC), members of its medical staff, and its Board of Directors, seeking damages for the permanent termination of his staff privileges. In his complaint, plaintiff alleged that HRMC violated state and federal antitrust laws, breached its contract with Dr. Bryan, and committed numerous other violations.

The trial judge denied the hospital's motions for summary judgment and directed verdict, finding that genuine

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[1] In 1986, Congress recognized that there was a medical malpractice crisis in this country which required intervention by the federal government. 42 U.S.C.A. § 11101(1). In an attempt to alleviate this crisis and improve the quality of medical care in the United States, Congress enacted the HCQIA. In pursuit of these goals, the HCQIA encourages the medical profession to rid itself of bad doctors by providing "good faith" peer review participants immunity from money damages if they comply with the professional review standards set forth in the Act. 42 U.S.C.A. § 11112(a). Peer review, the process by which physicians, hospitals, and other health care providers scrutinize the competence of physicians, has become a critical part of health care in the United States. For peer review to be effective, physicians and hospitals need certainty in the application of the federal statutory guidelines.

issues of material fact existed as to (1) defendant's right to protection under the federal HCQIA and state immunity statutes; (2) plaintiff's federal and state antitrust claims; and (3) plaintiff's breach of contract claim. Specifically, in denying defendant's motion for summary judgment on the HCQIA immunity issue, the trial judge ruled that the evidence in Dr. Bryan's case revealed that (1) the defendant ***rejected*** the hearing panel's recommendation; (2) the hospital's reasons were pretextual; (3) there was never any evidence that Dr. Bryan had ever placed a patient's life in danger (A.94-95)[2]; and (4) Dr. Bryan's conduct was not the type of conduct ordinarily sanctioned by permanent termination. (A.61-63)

At the close of all the evidence, the hospital requested the court to instruct the jury on the HCQIA immunity. Such request was granted. (A.107-108) Significantly, *the hospital* specifically asked the court to include the question of HCQIA immunity on the Special Verdict Form.[3] The trial judge denied this request.

After considering all the evidence and weighing the credibility of all the witnesses, the jury returned a verdict finding that the hospital wrongfully terminated Dr. Bryan's medical staff privileges in violation of its bylaws. (A.92-93)

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[2] There was never any question of Dr. Bryan's competency as a surgeon. (A.96-101;102-104;106) Before the hospital terminated his privileges, Dr. Bryan had been practicing as a general and vascular surgeon for approximately seventeen (17) years. While at the hospital, Dr. Bryan achieved the highest degree of training and recognition as a vascular surgeon of any of the surgeons on staff at the hospital. In fact, at the time of his termination, Dr. Bryan was the only person at the hospital who was Board Certified in vascular surgery. (A.99)

[3] The question submitted *by the hospital* was: "Is Holmes immune from monetary damages under the provisions of the Health Care Quality Improvement Act?" (A.109) The court of appeals ruled that the jury should not decide the HCQIA immunity. However, it was the hospital itself which invited such alleged error. This Court should also note that the jury instruction on the HCQIA immunity, submitted by the hospital, specifically explained to the jury that the hospital could not be liable for damages if it complied with the standards set forth in the HCQIA. (A.108)

After appropriate jury charges, the jury also found that a conspiracy to accomplish illegal acts had been proven by the greater weight of the evidence, and that the hospital's actions were prompted by bad faith and fraud. (A.110)

The hospital filed post-trial motions for new trial and judgment as a matter of law on the HCQIA immunity. (A.84-85) The trial judge ruled that the hospital was not entitled to the HCQIA immunity as a matter of law because the weight of the evidence supported the jury verdict in favor of Dr. Bryan. (A.79-80)

The hospital appealed that part of the jury verdict addressing Dr. Bryan's breach of contract claim only. It did not appeal the jury's finding with regard to the hospital's antitrust violations. Dr. Bryan cross-appealed the trial court's finding that he did not have standing to seek treble damages under the antitrust laws. The court of appeals did not address petitioner's antitrust cross-appeal in its opinion.

The court of appeals held that, despite the jury's finding that the hospital acted in bad faith and denied Dr. Bryan due process and fairness in the peer review process, and violated state and federal antitrust laws, and despite the trial court's post-trial ruling that the hospital was not entitled to immunity, Dr. Bryan failed to rebut the "rebuttable presumption" of the HCQIA.[4] In making this determination, the appellate court dismissed Dr. Bryan's evidence of bad faith as being irrelevant (A.45), and consequently dismissed key evidence which formed the basis of the trial court's rulings and the jury's verdict.

The evidence presented by Dr. Bryan at trial established that the reasons advanced by the hospital for Dr. Bryan's termination were pretextual and nothing more than a

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[4] The American Medical Association (AMA), with a membership in excess of 280,000 physicians, filed a brief on Dr. Bryan's behalf in the court of appeals, asserting that under the facts of this case, the hospital was ***not*** protected by the HCQIA immunity and the presumption was rebutted. (A.111-127) The American Hospital Association (AHA) disagreed with the AMA's interpretation of the HCQIA, and filed a brief asserting the applicability of the HCQIA.

subterfuge. The theory of plaintiff's case was that the hospital abused the peer review process to enforce a hidden agenda against this surgeon.

Dr. Bryan's evidence established that (1) direct economic competitors, who testified that they hated Dr. Bryan, actively participated in his peer review (A.128-135); (2) Dr. Bryan repeatedly complained about substandard care rendered by the hospital and its staff (A.136-145)[5]; and (3) Dr. Bryan's style of practice was different from that of other surgeons in that he performed longer and more costly surgeries on Medicare patients which lost money for the hospital.[6] (A.146-150)

First, direct economic competitors actively participated in Dr. Bryan's peer review process. It was Dr. Gurri, a general and vascular surgeon, a former partner of Dr. Bryan's, and a direct economic competitor of Dr. Bryan, who appointed the first ad-hoc committee which began the formal investigation procedures against Dr. Bryan. (A.106,129,131) Testimony at trial and at the Chanda panel hearings at trial also established that Dr. Gurri hated Dr. Bryan. (A.128,130-131)

After the first hearing panel (Ryon/1988) threw out all prior incident reports against Dr. Bryan as being "insignificant" (many were duplicates and had been filed by the same individuals) and part of a "seriously flawed system," Dr. Gurri told the Medical Executive Committee ("MEC") that it did not have to accept the Ryon panel's findings. (A.154-159) It was also Dr. Gurri who told the MEC at a meeting held October 9, 1989 that Dr. Bryan's privileges will be terminated if Dr. Bryan has any more serious incidents. (A.160)

Thereafter, on October 19, 1989, the Board wrote a letter to Dr. Bryan (cited in court's opinion) stating that any

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[5] The Appendix contains excerpts from the evidence produced at trial and included in the record before the court of appeals.

[6] Drs. Gurri and Armstrong (members of the MEC/Board of Directors and direct economic competitors) always made disparaging comments about Dr. Bryan, especially about the fact that he took too long in surgery. Comments were repeatedly made that the length of his surgeries was unacceptable. (A.151-153)

further unprofessional behavior would result in permanent suspension. (A.161-164)[7] Among those serving on the Board of Directors at this time and actively participating in Dr. Bryan's case were Drs. Gurri and Armstrong. (A.172-174) Dr. Armstrong, a member of the hospital's Board of Directors, had also been partners with Dr. Bryan in the past, and was a general and vascular surgeon. He was a direct economic competitor of Dr. Bryan, who testified under oath that he did not like Dr. Bryan. (A.132-135) Drs. Armstrong and Gurri were friends, and considered "politically powerful" at HRMC. (A.175) After Dr. Bryan's termination, Drs. Gurri's and Armstrong's surgeries increased. (A.176-180)

In that October 19, 1989 letter, the Board chastised Dr. Bryan for complaining about the substandard care rendered by the hospital's staff. The Board stated it would not tolerate such behavior. (A.161-164)

The incidents which occurred thereafter, and used by the hospital as justification for its actions[8], involved situations where Dr. Bryan chastised assistants who were placing a patient's life in danger in the middle of surgery. These assistants had reputations in the hospital for being incompetent. For example, other surgeons at HRMC testified that Tina Stark was "slow," "inattentive," and "difficult to work with." (A.181) Mike Greene was known to be inattentive and had a bad attitude about his work. He was ultimately fired by the

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[7] Teegen, a lead member of the Ryon Panel, told the jury that the allegations made by the Board in its letter were not the findings of the Ryon hearing panel. (A.167-171)

Further, Dr. Bryan wrote a response to the Board's letter advising the Board that its alleged "'pattern of disruptive behavior' was shown, again by sworn testimony, to be largely erroneous or frivolous while 'repeated warnings and counseling' were non-existent . . ." Dr. Bryan further wrote that his only goal is to serve the community by practicing "quality vascular surgery," and because his practice as a physician "depends entirely upon the generosity of the Board, [he] pledge[s] to abide by its recommendations to the best of his ability." (A.165-166)

[8] The hospital's version of these incidents is set forth in the lower court's opinion.

hospital. (A.182-184)

Evidence also established that the hospital administration itself instigated these incident reports against Dr. Bryan. For example, the incident reports filed by Ms. Stark were dictated and typed by someone in the hospital administration. (A.185-202) The evidence also established that the day after the incident in question, Mike Greene said his hand was never hurt and the incident was no big deal. (A.203) However, several days later, Dr. Bryan was written up for "striking" the hand of Mike Greene.[9]

Nurses and physicians testified at trial that there was a conspiracy against Dr. Bryan, and that the hospital and members of its staff were "out to get" Dr. Bryan and have him "thrown off the staff." (A.208-211) Nurses were told by hospital administration to write up Dr. Bryan if he did anything, no matter what. (A.212-215) Nurses also testified that Dr. Bryan was singled out and treated differently from other surgeons on the staff at HRMC. Evidence revealed that Dr. Bryan's behavior was no different than any other surgeons at HRMC, yet Dr. Bryan would be written up where other physicians would not have been.[10] (A.216-230)

On May 19, 1990, Dr. Bryan was summarily suspended without hearing by the MEC based on these recent incidents. The MEC had a meeting at which Dr. Gurri told the committee that Dr. Bryan had a "long history of disruptive behavior."

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[9] Dr. Bryan never admitted that the incident reports as written were true. Dr. Bryan testified to the jury that while some interaction had occurred, the incident reports were exaggerated and blown out of proportion. Further, these reports arose out of situations where "the patient wasn't [being] cared for." Dr. Bryan's goal at all times was to "give good care to patients." (A.204-207)

[10] Testimony at trial established that it was normal and often necessary behavior for surgeons to raise their voices or use non-verbal communications to make a distracted nurse or technician pay attention to the critical surgery at hand. (A.231-244)

The MEC voted to permanently terminate Dr. Bryan.[11]

The second hearing panel (Chanda) which was convened to review the four incident reports relied on by the hospital as additional justification for its actions, was described by one witness as being "McCarthy-like." (A.252) Members of the Chanda panel testified at trial that the MEC and the Hospital had already made up their minds, and the panel's recommendation would make no difference in the outcome of Dr. Bryan's case. (A.253-254) At a closed meeting, the panel considered the stack of old "seriously flawed" incident reports and relied on these reports in recommending a two-year suspension.[12] Dr. Bryan was never given the opportunity to respond to this stack of incident reports. (A.265-270)

The MEC, spearheaded by direct economic competitors of Dr. Bryan (Gurri and Armstrong), rejected the hearing panel's findings and voted to permanently terminate Dr. Bryan. (A.271-278)

Dr. Bryan appealed to the Board of Directors. Under the hospital's bylaws, the Board was required to review the record upon which the MEC recommendation was based. (A.279) The Chairman of the Board testified at trial that the Board never reviewed a record. It never reviewed transcripts from the prior panels. (A.280) All the Board considered were the prior incident reports, which had been deemed to be seriously flawed by a prior hearing panel. The Board affirmed

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[11] Testimony at trial established that the incident reports (taken together) did not support Dr. Bryan's termination, and that the hospital's actions violated the AMA's Code of Ethics. (A.245-251)

[12] The hospital came to the hearing with copies for all panel members of all the incident reports ever filed against Dr. Bryan, despite the earlier hearing panel's findings that these reports were "seriously flawed" and were "insignificant," and despite the fact that the MEC had told Dr. Bryan on July 10, 1989 that these prior incident reports would be thrown out. (A.255-264)

the permanent suspension of Dr. Bryan.[13]

After Dr. Bryan's permanent termination, HRMC reported Dr. Bryan to Department of Professional Regulation ("DPR"), claiming that Dr. Bryan was an impaired physician. DPR reviewed and dismissed these charges. (A.281)

REASONS FOR GRANTING PETITION

INTRODUCTION

This case warrants Supreme Court review because it concerns the construction and application of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. §§ 11101-11152. The court of appeals imposed a construction on the HCQIA which is in direct conflict with the express legislative intent underlying this Act, and applied the Act in a manner which violates a litigant's right to a jury trial under the Seventh Amendment to the United States Constitution. The lower court's construction also nullifies the summary judgment standard established by Federal Rule of Civil Procedure 56(c), and violates a physician's due process rights under the Fifth Amendment to the United States Constitution.

The court of appeals' holding that bad faith is immaterial to a determination of whether a defendant has complied with the good faith peer review requirements of the HCQIA is so inconsistent with the purpose and intent of the HCQIA as to leave the meaning of this federal statute in a

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[13] In its opinion, the court held that the obligation was on Dr. Bryan to provide the Board with a full record, including transcripts of the hearing panels, despite the fact that Section 44.4.1 of the hospital's bylaws specifically states that the "Chairman of the Board shall appoint a Board review panel...to consider the record upon which the recommendation before it was made." (A.279) As apparent from footnote 18 of the opinion, this particular provision of the bylaws was overlooked by the court. (A.31)

The court also held that Dr. Bryan should have told the Board *at the time* that it was required to obtain a transcript. Such a requirement, however, would have required Dr. Bryan to guess beforehand that the Board would not follow the plain dictates of its bylaws.

state of confusion. Further, the issues decided by the lower court concerning the effect to be given the statutory presumption of the HCQIA, Section 11112(a) are issues of first impression under this Congressional Act.[14]

The HCQIA was enacted in 1986, and became effective in 1989. While there has been activity in the lower appellate courts concerning the HCQIA, the United States Supreme Court has not yet had the opportunity to squarely address the proper construction and application of the protections afforded by this Act. Further, very few, if any, plaintiff physicians in a "peer review" case survive the summary judgment and directed verdict stages of litigation to obtain a jury verdict in their favor. Under the Eleventh Circuit's recent opinion, it will now be virtually impossible for any physician to obtain a jury trial in a peer review case.

Moreover, because of the lack of Supreme Court guidance on the HCQIA, the court of appeals relied on this Court's precedent regarding the Section 1983 qualified immunity (42 U.S.C. § 1983) in devising its new procedural standards. The propriety of applying the Section 1983 qualified immunity standards to HCQIA cases is an issue of exceptional importance which should be addressed by this Court. While Section 1983 qualified immunity cases have in fact been addressed by the Supreme Court, the Supreme Court has not had the opportunity to address such a standard in the HCQIA context.

Clearly, the Eleventh Circuit has decided an important question of federal law which has not been, but should be, settled by this Court. The issues presented in this case are substantial, and will have a tremendous impact on today's health care industry. These issues directly affect the rights of physicians in the practice of their livelihood, as well as the rights of hospitals and other participants in the peer review

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[14] The need for guidance by this Court is further illustrated by the fact that the American Medical Association (AMA) and American Hospital Association (AHA) filed amicus briefs before the court of appeals disagreeing on the proper interpretation of the HCQIA.

process.

I. THE COURT OF APPEALS HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT.

A. The Lower Court Imposed a Construction on the HCQIA Which is in Direct Conflict with the Act's Express Legislative Intent, and Applied the Act in a Manner Which Violates a Litigant's Constitutional Right to a Jury Trial, as well as Nullifies the Standards Established by Federal Rule of Civil Procedure 56.

1. Bad Faith Peer Review Is Not Protected by the HCQIA.

In its opinion, the court of appeals specifically ruled that "bad faith" is irrelevant to the question of whether a hospital is entitled to HCQIA immunity. As stated by the court in its opinion:

> Bryan's assertions of hostility do not support his position that the Hospital is not entitled to the HCQIA's protections because they are ***irrelevant*** to the reasonableness standards of § 11112(a). The test is an objective one, so ***bad faith is immaterial***.

(e.s.) (A.45)

Supreme Court review of such a ruling is necessary because this ruling is ***in direct conflict*** with the very purpose of the HCQIA, which is to "encourage good faith peer review." As stated in the preamble to the HCQIA:

> **A BILL**
> [T]o encourage ***good faith*** professional review

> activities of health care entities...

H.R.5540, 99th Cong., 2d Sess., Sept. 17, 1986. (A.283)

Furthermore, it was Congress' clearly expressed intent that bad faith peer review would not be protected by the HCQIA immunity. As stated by the sponsor of the HCQIA, Representative Henry Waxman, before the House of Representatives on October 17, 1986:

> ***Bad faith*** peer review activities...could never obtain immunity under H.R. 5540.

132 Cong. Rec. H11590 (daily ed. Oct. 17, 1986) (statement by Waxman). (A.331)

The opinion further conflicts with the legislative intent behind the HCQIA in that the lower court has construed and applied the immunity provided under the Act as a ***broad*** immunity. The legislative history makes clear that the immunity under the Act was intended by Congress to be very limited and narrow. 132 Cong. Rec. H11589 (daily ed. Oct. 17, 1986) (statement by Waxman).[15] (A.329-330) In defining exactly what situations would not fall under HCQIA

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[15] One of the crucial errors in the lower court's opinion is that it relied on legislative history which was clarified by subsequent legislative review. The Energy and Commerce Committee, which sponsored the initial bill, submitted a preliminary report on September 26, 1986. (A.284-305) This is the report relied upon by the court in its opinion. Yet it was only after this initial report was submitted that the true legislative scrutiny process began. The Judiciary Committee conducted hearings on this bill in October 1986, and as a result of these hearings the bill was substantially amended. The primary purpose of these amendments was to protect physicians from abuses of the peer review system. 132 Cong. Rec. H9957 (daily ed. Oct. 14, 1986) (statement by Waxman). (A.320) These hearings, held October 8 and 9, 1986, as well as the floor debates conducted before the House of Representatives on October 14 and 17, 1986, reveal the true legislative intent behind this Act. Pertinent excerpts of this legislative history are located in the Appendix to this petition. (A.306-332)

immunity, Congress stated:

> For example, an action taken against a physician because of a ***style of practice*** or a ***pattern of patients*** that does not generate sufficient revenue for a hospital would not be covered by this bill.
>
> * * *
>
> Professional review actions taken in retaliation against whistleblowers are not protected under the bill.

(*e.s.*) 132 Cong. Rec. H9959 (daily ed. Oct. 14, 1986) (statement by Waxman). (A.322-323)

The lower court's opinion misinterprets and misapplies the HCQIA. The opinion indicates that as long as the hospital advances reasons for its actions, and offers some evidence in support of its reasons, it is entitled to the HCQIA immunity. The fact that it acted in bad faith is "immaterial," and the fact that the hospital's reasons may be a subterfuge for improper reasons is irrelevant.

Contrary to the court of appeals' opinion, Congress specifically recognized that while a hospital may ***say*** it was acting to further the quality of health care, and may indeed offer evidence to support its actions, the hospital is not automatically entitled to immunity. Congress recognized that the peer review process may be used as a subterfuge for other activities, in which case the immunity would not apply. As stated by Representative Waxman before the House of Representatives on October 14, 1986:

> The immunity provisions have been restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions that . . . are really taken for anticompetitive purposes will not be protected under this bill.
>
> * * *

> This subsection reflects the concern that professional review actions brought for illegitimate reasons may not appear as such on their face.
>
> * * *
>
> The more serious issues arise when actions are stated to be for legitimate reasons, but are challenged as not being genuinely based on the competence or professional conduct of an individual physician.

132 Cong. Rec. H9957, H9959 (daily ed. Oct. 14, 1986) (statement by Waxman). (A.320-323)

The deliberations which occurred during the October 1986 hearings before the Judiciary Committee further reveal Congress' intent that the HCQIA immunity is a very limited immunity, as well as Congress' recognition that the health care profession is becoming more competitive every day, and a hospital's reasons for its peer review actions are not always what they appear to be:

> [Mr. GLASBERG] [W]hen some doctors decide to get rid of the doctor who is serving the . . . poor patients, they are not going to say that is why they are doing it. They are going to say they are doing it because he is not providing good services. . . . he is not providing good patient care. . . . and take a look at these records which we've dug up.
>
> * * *
>
> [Mr. GLASBERG] No hospital committee is going to expel a doctor for an expressly illegitimate reason . . .
>
> * * *
>
> [Mr. WEINSTEIN] [T]he likelihood is that [the peer review] process will be abused for anticompetitive or what I could call antisocial purposes.

* * *

> [Ms. DAVIS] Is it sometimes possible that a physician will be denied privileges because a doctor's patient load has a high proportion of uninsured or indigent persons . . .
>
> [Mr. HALPER] It more likely would be an abuse if you leave in the words 'professional competency' rather than 'quality of care' . . . Quality of care is harder to define except in terms of actual procedures. 'Professional conduct' masks a lot of other types of activity.
>
> [Mr. WEINSTEIN] [T]here is very realistically such a possibility in this day and age where hospitals . . . are concerned about their profitability. We run the risk with this bill that a practitioner is going to have a negative mark reported nationwide merely because of the nature of the population that he or she serves. That is really something we do not want to encourage.
>
> [Dr. WOLFE] If a hospital tried to take action against a physician because the physician happened to be more concerned with poor people and had a practice made up more largely of poor people than someone else, that should be the subject of reward, not discipline.

Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Committee on the Judiciary, 99th Cong., 2d Sess., 66,77,86,90,95,125-126 (Oct. 8 and 9, 1986). Pertinent excerpts from the transcripts of these hearings are located in the appendix to this petition. (A.306-319)

Dr. Bryan submitted evidence from which both the trial judge and a jury could find, and did in fact find, that the hospital used the peer review process as a subterfuge to

terminate him because of his style of practice and pattern of patients. The bulk of Dr. Bryan's practice involved older patients on Medicare. He was very innovative, and performed very lengthy and complicated surgeries on his patients. The evidence at trial established that such a style of practice was not profitable for the hospital. (A.146-150)

Further, Dr. Bryan often complained about the substandard care of hospital nurses and technicians, and on a few occasions other doctors. (A.136-145;207) The hospital Board even chastised Dr. Bryan in its October 1989 letter which, contrary to the hearing panel's findings, accused him of being disruptive. (A.161-171) A trier of fact could infer, and in fact did infer, from such evidence that Dr. Bryan was terminated in retaliation to his constant complaints of substandard patient care by the hospital staff.[16]

2. The Question of Whether a Defendant Complied with the Immunity Standards of Section § 11112(a) of the HCQIA Should be a Question for the Jury When There Exists a Dispute as to Genuine Issues of Fact.

Supreme Court review of the Eleventh Circuit's opinion in this case is warranted because the lower court has created a "new" standard to be applied in the litigation of HCQIA cases. The court of appeals has specifically ruled that the question of whether a defendant has complied with the four immunity standards of the HCQIA, as set forth in 42 U.S.C.A. § 11112(a), is never a question for the jury, even if there exist

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[16] Congress never intended the term "unprofessional conduct" to encompass the conduct at issue in this case. As recognized by Congress, unprofessional conduct includes "felonies or crimes of moral turpitude. . . illicit transactions involving drugs, serious sexual offenses, violent behavior, and other similar acts." 132 Cong. Rec. H9959 (daily ed. Oct. 14, 1986) (statement by Waxman).

genuine issues of fact.[17] As stated by the court of appeals:

> A district court should consider the issue of HCQIA immunity from damages at the summary judgment stage. If it determines that the defendant is not entitled to such protection, then the merits of the case should be submitted to the jury without reference to the immunity issue. If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether the disciplined physician was given adequate notice of the charges and the appropriate opportunity to be heard, the court may ask the jury to resolve the subsidiary factual questions by responding to special interrogatories. [citations omitted] ***Under no circumstances should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury.***

(A.39-40)

According to the court, the HCQIA presumption creates an "unusual" summary judgment standard. (A.41)

Supreme Court guidance is necessary in the present case because the issues raised by the court of appeals are issues of first impression under the HCQIA:

> (1) On a motion for summary judgment, what procedural effect is to be given the statutory presumption that a defendant acted in accordance with the four immunity standards of subsection 11112(a)?
>
> (2) In view of the HCQIA presumption, is a defen-

---

[17] Questions concerning "reasonableness" and "fairness under the circumstances," are classic jury questions. 42 U.S.C.A. § 11112(a).

dant's compliance with the HCQIA immunity standards a question for the trial judge or the jury when there exist genuine issues of fact?

The "new" standard created by the lower court[18] is contrary to the legislative intent underlying the HCQIA, nullifies the summary judgment standard established by Federal Rule of Civil Procedure 56, and as applied by the court, violates the Seventh Amendment to the United States Constitution.

The HCQIA does not provide that compliance with the immunity standards is a factual issue to be determined any differently from other factual issues in the case. The HCQIA simply permits the judge on an early motion to decide whether the plaintiff has come forward with sufficient evidence for a jury to find noncompliance by a preponderance of the evidence.

The Act does not suggest that, on a motion for summary judgment, the judge is to assess whether the plaintiff has met this burden of persuasion. By providing that compliance with the immunity standards is presumed unless rebutted by a preponderance of the evidence, the HCQIA indicates that once the litigation has reached the trial phase, the burden rests on the plaintiff to persuade the factfinder that the defendant did not comply with the four standards.

This interpretation is consistent with other legislative history describing the rationale for imposing a "preponderance of the evidence" standard rather than a "clear and convincing" standard. The former was favored by Congress to determine noncompliance with the immunity provisions because it was the same standard applied to the determination of other factual issues in an antitrust or breach of contract case. Second, the HCQIA does not expressly provide for judicial factfinding on compliance with the immunity standards. Third, judicial factfinding on the issue of noncompliance with HCQIA could create a conflict with the jury's factfinding on the underlying

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[18] The trial judge did not have the benefit of this new standard.

antitrust or breach of contract claims at trial. Finally, this interpretation that compliance with HCQIA's immunity standards is a jury question where the evidence shows a genuine dispute of material fact, is consistent with the allocation of decision-making functions between judge and jury on an analogous immunity question that raises factual issues of the defendants' "reasonable beliefs," namely, the issue of qualified immunity for executive officials in a civil rights action. The majority of courts hold that, to resolve the issue of qualified immunity, the judge must submit to the jury all genuine issues of fact as to what actually happened. See *Medical Peer Review, Antitrust, and the Effect of the Statutory Reform*, 50:316 MARYLAND L. REV., pp.379-381 (1991) (authored by Charity Scott) (the non-moving party's burden under the HCQIA); Note, *Qualified Immunity and the Allocation of Decision-Making Functions Between Judge and Jury*, 90 COLUM. L. REV. 1045, 1051-56 (1990) (majority of courts hold that, to resolve issue of qualified immunity, the judge must submit to the jury all genuine issues of fact as to what actually happened).

The court of appeals also relied on language from the Committee Report which states that the Act "would allow a court to make a determination that the defendant has or has not met the (immunity) standards. . . ." to support its holding that it is the court, and not the jury, which determines compliance with the professional review standards of the HCQIA. H.R. Rep. No. 903, 99th Cong., 2d Sess. 12, *reprinted in* 1986 U.S.C.C.A.N. 6394. However, it is evident from the legislative intent of the HCQIA that while the creation of a presumption would allow for early resolution of frivolous or insubstantial claims, Congress clearly anticipated that the immunity issue would go to the jury if there was any issue of fact.[19] The legislature never intended to shift the normal

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[19] In response to the concerns raised by the Judiciary Committee, Representative Waxman told Congress:

> You object to the presumption regarding professional review actions that requires clear and convincing

burden of proof for civil trials.[20]

Furthermore, to support its new standard, the court of appeals erroneously relied on this Court's Section 1983 "qualified immunity" line of cases. (A.39) However, modern qualified immunity standards do not change the standard for the availability of summary disposition. If there is no genuine dispute as to what happened, the judge may not withhold summary disposition; if there is a factual dispute, however, it must be resolved by the jury. If plaintiff's version of the facts would not give rise to immunity, while defendant's version would, and a genuine issue of fact is created, the trial judge must submit to the jury all genuine issues of fact relevant to the qualified immunity issue. The Section 1983 qualified immunity, or the "rebuttable presumption" in HCQIA cases, allows for early disposition of frivolous or insubstantial lawsuits only - - not for substantive lawsuits in which a plaintiff is able to create an inference of fact. See McSurely

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> evidence. You suggest that it would create needless complexity ***in the minds of the jury*** to apply different standards, thereby adding to the confusion and potential delay of a peer review trial in court . . . I have modified the presumption to substitute the clear and convincing evidence test with a preponderance of the evidence test . . . Such a step should simplify the immunity provisions.

(e.s.) 132 Cong. Rec. H11590 (daily ed. Oct. 17, 1986) (statement by Rep. Waxman). (A.331-332)

[20] In clarifying that the standards are not to be pleaded and proved by the defendant as an affirmative defense, the Legislature stated:

> Such an interpretation would have shifted the normal burden of proof for civil trials and was never intended by the Committee on Energy and Commerce.

132 Cong. Rec. H9958 (daily ed. Oct. 14, 1986) (statement by Rep. Waxman). (A.321) Further, one of the purposes of the Act was to lessen litigation complexity. See 132 Cong. Rec. H11590 (daily ed. Oct. 17, 1986) (statement of Rep. Edwards). (A.331-332) The new standard imposed by the court of appeals is in conflict with such purpose.

v. McClellan, 697 F.2d 309 (D.C.Cir. 1982) (Harlow does not propose to change the operation of Rule 56 in immunity cases. . . . When there is a genuine issue of fact . . . Rule 56 compels a trial). This Court in Harlow v. Fitzgerald, 457 U.S. 800 (1982), acknowledged that "disputed questions of fact ordinarily may not be decided on motions for summary judgment."

The Supreme Court in Mitchell v. Forsyth, 472 U.S. 511 (1985), is even clearer when it states:

> [I]f the plaintiff's complaint adequately acknowledges the commission of acts that violated clearly established law, the defendant is entitled to summary judgment if discovery ***fails to uncover evidence sufficient to create a genuine issue as to whether the defendant in fact committed those acts.***

If discovery does create a factual issue, Mitchell explicitly envisions that the suit proceed to trial:

> At trial, the plaintiff may not succeed in proving his version of the facts, and the defendant may thus escape liability.

The court of appeals' opinion misconstrues Supreme Court precedent regarding the Section 1983 qualified immunity standards. The Supreme Court never intended to depart from standards governing the availability of summary judgment and trial by jury. The Court's qualified immunity cases indicate that the Court intended to leave to the jury only that which cannot constitutionally be withheld from the jury. Any other ruling is incompatible with Rule 56 and the Seventh Amendment.

The court of appeals' application of the federal statute in this case violates the Seventh Amendment to the United States Constitution. If either party demands a jury trial, the Seventh Amendment prohibits the trial court from engaging in fact identification. See e.g., In re Peterson, 253 U.S. 300, 312

(1920) ("The limitation imposed by the [Seventh] Amendment is that . . . the ultimate determination of issues of fact by the jury not be interfered with."). In a case in which plaintiff's version of the facts would not give rise to qualified immunity, but defendant's version would, and a genuine issue exists as to which version is correct, the jury must resolve those factual issues.

The lower court cites Islami v. Covenant Medical Center, Inc., 822 F.Supp. 1361 (N.D.Iowa 1992) as additional support of its "new" standard under the HCQIA. However, Islami clearly mandates affirmance of Dr. Bryan's case.[21]

In Islami, the court held that evidence in a doctor's lawsuit against a hospital for suspension of staff privileges raised jury issues as to whether procedures defendants afforded to the doctor were "fair under the circumstances," and precluded summary judgment on a breach of contract claim and on the issue of whether defendants were entitled to immunity under the HCQIA. The court held that "'fairness based on the circumstances' is the paradigm jury question." As stated by the court:

> The factual circumstances are complicated and hotly disputed in this case. For the court to say whether the proceedings were fair under the circumstances at this juncture would require the court to draw numerous inferences and weigh the evidence of the parties; a process which is anathema to summary judgment decisions.
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> * * *
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> The Court implies that the extraordinary case still may go to the jury for some help. This case is extraordinary because the decision on

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[21] Islami also illustrates the confusion among the lower federal courts as to the proper legal standard to be applied in HCQIA cases. Islami, 822 F.Supp at 1377-1379, citing Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992) and Fobbs v. Holy Cross Health System Corp., 789 F.Supp. 1054 (E.D.Cal. 1992) (advancing different summary judgment standards when HCQIA an issue).

> immunity is hopelessly intertwined with a decision on the merits of the contract claim which this court already has found cannot be decided by summary judgment.
>
> * * *
>
> [t]heir failure to carefully follow the by-laws and HCQIA generates a jury issue.

Islami, 822 F.Supp. at 1361, 1374, 1378-79.[22]

3. A Physician Cannot Be Afforded Due Process under the HCQIA as a Matter of Law if Direct Economic Competitors of that Physician Actively Participated in the Peer Review Proceedings.

As set forth at pages 9-12 of this petition, direct economic competitors instigated review of Dr. Bryan, and direct economic competitors were responsible for his permanent termination from the hospital staff.

In enacting the HCQIA, Congress made clear that a physician must receive ***unbiased review*** in the peer review process. As stated in its legislative history:

> In any case, it is the Committee's intent that physicians receive ***fair and unbiased review*** to protect their reputations and medical practices.

(e.s.) H.R. No. 99-903, 99th Cong., 2d Sess., p.6393.

The HCQIA provides that in order for a professional review body to have immunity, it must comply not only with the "reasonable belief" requirements of the Act, but also due process. As stated in 42 U.S.C.A. 11112(a)(3), a professional

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[22] Even if the court of appeals' "new" standard is ultimately considered to be the proper standard to be applied in HCQIA cases, that standard was misapplied by the court of appeals in the present case.

review action must be taken:

> (3) after adequate notice and hearing procedures are afforded to the physician involved or ***after such other procedures as are fair to the physician under the circumstances.***

The HCQIA also provides that the hearing panel must be impartial and fair in evaluating a physician's behavior. As stated in 42 U.S.C.A. § 11112(b)(3)(A)(iii):

> (A) subject to paragraph (b), the hearing shall be held . . .
>
> * * *
>
> (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved.

When drafting this portion of the statute, Congress anticipated that the hearing panel would be the entity who, after weighing the evidence, made the decision as to what action should be taken against a physician based on the evidence. In this case, the MEC and Board of Directors, spearheaded by Drs. Gurri and Armstrong, direct economic competitors of Dr. Bryan who actively participated in Dr. Bryan's peer review, rejected the hearing panel's recommendation and permanently terminated Dr. Bryan's privileges. This is not "fair and unbiased" review and is in direct violation of the HCQIA. The "fair and unbiased" review requirements of the HCQIA should apply to all phases of the peer review proceedings.[23] To interpret the HCQIA, a federal statute, to

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[23] Furthermore, the hospital's own bylaws specifically recognize that a doctor cannot receive "fair and unbiased" review if direct economic competitors participate in the peer review. As provided in Section 10.2.12 of the hospital's bylaws (A.282):

> In any instance where a member of the Executive

mean that a physician can be afforded due process in the peer review process despite the fact that direct economic competitors actively participated in his peer review constitutes a violation of a physician's fundamental due process rights under the United States Constitution.

4. Dr. Bryan Rebutted the HCQIA Presumption as a Matter of Law.

Also worthy of this Court's consideration is the following issue raised by the court of appeal's opinion: If a plaintiff comes forward with some evidence to rebut the statutory presumption, what is the test for determining whether such evidence is sufficient to rebut the presumption and avoid summary judgment? The Act does not set forth such a test.

Evidence demonstrating that (a) direct economic competitors actively participated in the peer review process; (b) the peer review proceedings were conducted in bad faith; and (c) permanent termination was motivated by improper economic reasons should be sufficient to rebut the HCQIA presumption as a matter of law.

No matter what standard is applied, Dr. Bryan clearly rebutted the HCQIA presumption. Evidence at trial demonstrated that (1) direct economic competitors, who testified that they hated Dr. Bryan, actively participated in his peer review (A.128-135); (2) Dr. Bryan repeatedly complained about substandard care rendered by the hospital and its staff, and Dr. Bryan was terminated in retaliation to his whistleblowing (A.136-145); and (3) Dr. Bryan's style of practice was different from that of other surgeons in that he performed longer and more costly surgeries on Medicare patients which

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> Committee has a conflict of interest in any matter involving another appointee to the staff . . . that member shall not participate in the discussion or voting on the matter.

The jury found that the hospital violated its own bylaws inasmuch as direct economic competitors actively participated in Dr. Bryan's peer review.

lost money for the hospital. (A.146-153)

As in Islami, supra, Dr. Bryan demonstrated that a reasonable jury could find that he has shown by a preponderance of the evidence that the defendants did not provide him with fair and adequate process under the circumstances, and that defendants did not act in the reasonable belief that its action was to further quality health care.

The factual circumstances were complicated and hotly disputed in this case, and there can be no question that the decision on immunity was "hopelessly intertwined" with the merits of Dr. Bryan's contract and antitrust claims. For the court to say whether the defendant acted in the "reasonable relief" that it was furthering "quality health care," or that Dr. Bryan received fair treatment under the circumstances, requires a court to draw numerous inferences and weigh the credibility of the witnesses presented by the parties. This is a process which is anathema to summary judgment.

The jury heard the evidence presented by both parties, including the hospital's evidence as set forth in the lower court's opinion, and the jury found by a preponderance of the evidence that Dr. Bryan was not treated fairly, given the entire factual circumstances of this case, and that the hospital had breached its own bylaws and violated antitrust laws. Further, the trial judge decided the immunity issue as a matter of law when it denied the hospital's motions for summary judgment, directed verdict, and judgment as a matter of law, finding that genuine issues of material fact existed as to (1) defendant's right to protection under federal and state immunity statutes; (2) federal and state antitrust claims; and (3) plaintiffs' breach of contract claim.

II. THE LOWER COURT HAS SO FAR DEPARTED FROM THE ACCEPTED AND USUAL COURSE OF PROCEEDINGS AS TO CALL FOR THIS COURT'S POWER OF SUPERVISION.

The lower court violated fundamental standards of review established by the United States Supreme Court. First, the law is well established that on a motion for summary judgment, directed verdict, or judgment as a matter of law, the evidence is to be viewed in the light most favorable to the prevailing party - - in this case Dr. Bryan, who obtained a jury verdict in his favor. The prevailing party is to be given the benefit of all favorable inferences drawn from the evidence; and conflicts of the evidence are to be resolved in the prevailing party's favor. The weighing of the evidence is within the exclusive province of the trier of fact, and is beyond the scope of appellate review. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986).

The court of appeals has held in its opinion that issues of fact regarding a defendant's compliance with the HCQIA standards of "reasonable belief" and due process should be decided by the trial judge. The trial judge in this case weighed the facts at the summary judgment and directed verdict stages, and determined that the hospital was not entitled to immunity as a matter of law because the defendants' compliance with the professional review standards of the HCQIA was a question of fact. The trial judge let the issues of fairness, due process, and "reasonable belief" go to the jury. These issues formed the basis of plaintiff's breach of contract and antitrust counts. As in Islami, the plaintiff's breach of contract and antitrust counts were "intertwined" with the issue of whether the hospital complied with the "reasonable belief" and due process requirements of the HCQIA. After the verdict, and the hospital's motions for new trial and judgment as a matter of law based on the HCQIA, the trial judge again weighed the evidence and determined that the weight of the evidence supported the jury verdict. After weighing the facts, the trial judge found that the defendant hospital was therefore not entitled to HCQIA immunity as a matter of law. (A.79-80,84-85)

Inasmuch as the trial judge's determination on the HCQIA immunity issue is dependent on his findings of fact, the appropriate standard of review is the "clearly erroneous" standard. Federal Rule of Civil Procedure 52(a) states as follows:

> Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge the credibility of the witnesses.[24]

See also Icicle Seafoods, Inc. v. Worthington, 475 U.S. 709 (1986) (applying Fed. R. Civ. P. 52(a) standard); Mendoza v. Block, 27 F.3d 1357 (9th Cir. 1994) ("clearly erroneous" standard applied to district court findings re § 1983 qualified immunity).

In this case, the court of appeals offered factual rather than legal grounds for its reversal of the district court's findings and the jury verdict.[25] The court in its opinion never identified the standard of review it was applying to the district court's factual findings. The United States Supreme Court has

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[24] This rule is based upon the public interest in the stability and judicial economy that would be promoted by recognizing that the trial court, not the appellate tribunal, should be the finder of the facts. To permit courts of appeals to share more actively in the fact-finding function would tend to undermine the legitimacy of the district court in the eyes of litigants, multiply appeals by encouraging appellate retrial of some factual issues, and needlessly reallocate judicial authority. Advisory Committee Notes, 1985 Amendment to Fed. R. Civ. P. 52(a).

[25] The court of appeals also departed from the usual course of proceedings in that it did not consider any of the evidence presented at trial concerning defendant's antitrust violations. The court of appeals believed that because its decision was premised on the HCQIA immunity, it was unnecessary to consider such evidence. (A.51-52) Certainly any evidence of antitrust violations would be relevant to the issue of whether the hospital complied with the "good faith" and/or "reasonable belief" peer review requirements of the HCQIA.

held that a court of appeals' failure to properly apply this standard is improper and constitutes reversible error. As stated by the United States Supreme Court in Amadeo v. Zant, 486 U.S. 214, 224 (1988):

> It is well settled, however, that a federal appellate court may set aside a trial court's findings of fact ***only*** if they are 'clearly erroneous,' and that it must give 'due regard' . . . to the opportunity of the trial judge to judge the credibility of the witnesses. Fed. R. Civ. Proc. 52(a) . . .
>
> We have stressed that the clearly erroneous standard of review is a deferential one explaining that 'if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently. . . .[26]

As in Amadeo, the court of appeals in this case failed to properly apply the "clearly erroneous" standard of review and therefore committed reversible error. This particular issue is worthy of this Court's consideration inasmuch as the issue of whether the "clearly erroneous" standard is applicable to a district court's findings regarding the HCQIA immunity is of exceptional importance and has yet to be addressed by this Court.

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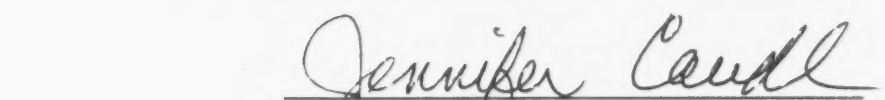
[26] The Supreme Court also held that the district court need not detail the basis for its factual conclusions. As stated in Amadeo:

> The district court's lack of precision, however, is no excuse for the court of appeals to ignore the dictates of Rule 52(a) and engage in impermissible appellate fact-finding.

CONCLUSION

The court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court. Peer review has become a critical part of the health care industry in the United States. For peer review to be effective, physicians and hospitals require certainty in the construction and application of federal statutory guidelines. The court of appeals' decision leaves the intent and meaning of the HCQIA in a state of confusion. The court of appeals' new procedural standard to be applied in the litigation of HCQIA cases raises an issue of first impression under this federal statute. Because of the major implications of the court of appeal's decision, and because of the need for the Supreme Court's guidance on the proper construction and application of the HCQIA, petitioners respectfully request this court to grant this petition for writ of certiorari.

Respectfully submitted,



Jennifer S. Carroll
Metzger, Sonneborn & Rutter, P.A.
1545 Centrepark Drive North
West Palm Beach, Florida 33401-7414
(407) 684-2000
Counsel of Record

George H. Moss
Moss, Henderson, Van Gaasbeck,
Blanton & Koval
Post Office Box 3406
Vero Beach, Florida 32964-3406

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No. OFFICE OF THE CLERK

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1994

FLOYD T. BRYAN, and
FLOYD T. BRYAN, M.D., P.A., Petitioners,

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,
Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

VOLUME I

Jennifer S. Carroll
Metzger, Sonneborn & Rutter, P.A.
1545 Centrepark Drive North
West Palm Beach, Florida 33401-7414
(407) 684-2000
Counsel of Record

George H. Moss
Moss, Henderson, Van Gaasbeck,
Blanton & Koval
Post Office Box 3406
Vero Beach, Florida 32964-3406

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August 27, 1992 Post-Trial Order, U.S. District Court, Middle District A.74-81

July 7, 1992 Motion for Judgment as a Matter of Law Pursuant to Rule 50(b), U.S. District Court, Middle District A.82-86

December 9, 1994 Order Denying Petition for Rehearing, Eleventh Circuit Court of Appeals A.87-89

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BRYAN v. JAMES E. HOLMES REGIONAL MEDICAL CENTER

Floyd T. BRYAN; Floyd T. Bryan, M.D., P.A., Plaintiffs-Appellees, Cross-Appellants,

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER, a/k/a Holmes Regional Medical Center, Inc., Defendant-Appellant, Cross-Appellee,

Raymond A. Armstrong, M.D., individually and as Chairman, Department of Surgery, HRMC and as Member of the Board of Directors, HRMC; Richard N. Baney, M.D., individually and as Member of the Board of Directors, HRMC; Michael J. Foley, M.D., individually and as Medical Director, HRMC; Michael V. Gatto, individually and as Member of the Board of Directors, HRMC; James E. Gray, III, individually and as Secretary of the Board of Directors, HRMC; Joseph A. Gurri, M.D., individually and as Chief of the Medical Staff, HRMC; Martin W. Isenman, M.D., individually and as Member of the Board of Directors, HRMC; David M. Jones, Maj. Gen. (Retired), individually and as Treasurer of the Board of Directors, HRMC; Michael F. Maguire, individually and as Member of the Board of Directors, HRMC; Fred L. McFarlin, individually and as Member of the Board of Directors, HRMC; John E. Miller, Ph.D., individually and as Second Vice Chairman of the Board of Directors, HRMC; Barry A. Mills, M.D., individually and as Chairman, Executive Committee, HRMC; Lyle Saltzman, M.D., individually and as Member of the Executive Committee, HRMC; Val M. Steele, individually and as Member of the Board of

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Directors, HRMC; Lynn Stoldt, R.N., individually and as Head Operating Room Nurse, HRMC; Russell P. Sullivan, Jr., individually and as Chairman of the Board of Directors, HRMC; John F. Turner, Jr., individually and as First Vice Chairman of Board of Directors, HRMC; Rita Wheeler, R.N., individually and as Operating Room Supervisor, HRMC, Defendants.

No. 92-2963.

United States Court of Appeals,
Eleventh Circuit.

Oct. 4, 1994.

Physician brought action against hospital that terminated his staff privileges. The United States District Court for the Middle District of Florida, No. 90-896-ORL-18, G. Kendall Sharp, Jr., entered judgment in favor of physician, and hospital appealed. The Court of Appeals, Tjoflat, Chief Judge, held that hospital was immune from liability for monetary damages under Health Care Quality Improvement Act (HCQIA).

Reversed.

1. Hospitals --6

HCQIA immunity is question of law for court to decide and may be resolved whenever record in particular case becomes sufficiently developed. Health Care Quality Improvement Act of 1986, §§ 402-432, 42 U.S.C.A. §§ 11101-11152.

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2. Hospitals --6

Congress intended HCQIA to permit defendants in suits arising out of peer review disciplinary decisions to file motions to resolve issues concerning immunity from monetary liability as early as possible in litigation process. Health Care Quality Improvement Act of 1986, §§ 402432, 42 U.S.C.A. §§ 11101-11152.

3. Federal Civil Procedure --2554

Hospitals --6

Although immunity under HCQIA may be determined at summary judgment stage, resolution of that issue may be deferred until or after trial if standards of summary judgment rule cannot be satisfied; substantive standards under HCQIA remain the same regardless of point at which immunity determination occurs. Fed. Rules Civ. Proc. Rule 56, 28 U.S.C.A.; Health Care Quality Improvement Act of 1986, §§ 402-432, 42 U.S.C.A. §§ 11101-11152.

4. Federal Civil Procedure --2554

District court should consider issue of HCQIA immunity from damages at summary judgment stage; if it determines that defendant is not entitled to such protection, then merits of case should be submitted to jury without reference to immunity issue. Fed. Rules Civ.Proc.Rule 56, 28 U.S.C.A.; Health Care Quality Improvement Act of 1986, §§ 402-432, 42 U.S.C.A. §§ 11101-11152.

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5. Federal Civil Procedure --2214

Hospitals --6

If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether disciplined physician was given adequate notices of charges and appropriate opportunity to be heard, court may ask jury to resolve subsidiary factual questions by responding to special interrogatories; under no circumstances should ultimate question of whether defendant is immune from monetary liability under HCQIA be submitted to jury. Fed.Rules Civ.Proc.Rule 56, 28 U.S.C.A.; Health Care Quality Improvement Act of 1986, §§ 402-432, 42 U.S.C.A. §§ 11101-11152.

6. Federal Civil Procedure --2546

In ruling on motion for summary judgment on issue of hospital's immunity from liability under HCQIA, court's inquiry focuses on whether physician provided sufficient evidence to permit jury to find that physician had overcome, by preponderance of the evidence, presumption that hospital would reasonably have believed that it had met standards of immunity provision. Fed.Rules Civ.Proc.Rule 56, 28 U.S.C.A.; Health Care Quality Improvement Act of 1986, § 412(a), 42 U.S.C.A. § 11112(a).

7. Hospitals --6

If jury returns verdict awarding damages to disciplined physician but evidence at trial conclusively demonstrates that defendant has satisfied HCQIA standards for peer review

procedures, thereby being entitled to immunity from monetary liability, then court should grant posttrial judgment as matter of law. Fed.Rules Civ.Proc.Rule 50(b), 28 U.S.C.A.; Health Care Quality Improvement Act of 1986, § 412(a), 42 U.S.C.A. § 11112(a).

8. Hospitals --6

Decision by hospital's board of directors to revoke physician's staff privileges, based on recommendation of peer review panel and executive committee, was "professional review action" within meaning of HCQIA. Health Care Quality Improvement Act of 1986, § 431(9), 42 U.S.C.A. § 11151(9).

See publication Words and Phrases for other judicial constructions and definitions.

9. Hospitals --6

Hospital's board of directors acted as a "professional review body" within meaning of HCQIA when they decided to revoke physician's staff privileges. Health Care Quality Improvement Act of 1986, § 431(4)(a)(i), (11), 42 U.S.C.A. § 11151(4)(a)(i), (11).

See publication Words and Phrases for other judicial constructions and definitions.

10. Hospitals --6

Hospital's termination of physician's clinical privileges met

requirements of HCQIA, entitling hospital to immunity from liability for monetary damages; revocation was prompted by reasonable belief that doing so would promote quality health care, in view of physician's pattern of unprofessional conduct over period of many years, decision was made only after physician's conduct had been evaluated by executive committee, peer review panel, and appellate review panel, and hospital complied with statutory procedural requirements. Health Care Quality Improvement Act of 1986, §§ 411(a), 412(a, b), 42 U.S.C.A. §§ 11111(a), 11112(a, b).

11. Hospitals --6

Hospital's decision to terminate physician's clinical privileges was taken "in the reasonable belief that the action was in the furtherance of quality health care," within meaning of immunity provision of HCQIA; physician had exhibited pattern of unprofessional conduct over period of many years, was given series of opportunities to remedy his difficulties in interacting with other staff members, and hospital concluded that physician's presence in operating room and patients' rooms was disruptive and interfered with important work of other employees. Health Care Quality Improvement Act of 1986, § 412(a)(1), 42 U.S.C.A. § 11112(a)(1).

See publication Words and Phrases for other judicial constructions and definitions.

12. Hospitals --6

Hospital's board of directors decided to terminate physician's staff privileges "after a reasonable effort to obtain

the facts of the matter," within meaning of HCQIA immunity provision; board terminated physician's privileges only after his conduct had been evaluated by executive committee, peer review panel, and appellate review panel. Health Care Quality Improvement Act of 1986, § 412(a)(2), 42 U.S.C.A. § 11112(a)(2).

See publication Words and Phrases for other judicial constructions and definition.

13. Hospitals --6

Hospital's board of directors satisfied procedural requirements of HCQIA when terminating physician's staff privileges, as required to be entitled to immunity from liability for monetary damages; hospital complied with notice requirements, hearings were held in timely fashion in accordance with hospital bylaws, and physician was afforded full rights of representation, cross-examination, and confrontation, Health Care Quality Improvement Act of 1986, § 412(a)(3), (b), 42 U.S.C.A. § 11112(a)(3), (b).

14. Hospitals --6

Hospital board's decision to terminate physician's staff privileges was made "in the reasonable belief that the action was warranted by the facts known," within meaning of HCQIA immunity provision; physician conceded that incidents that led to his termination actually occurred, and hospital had reasonable belief that termination was warranted. Health Care Quality Improvement Act of 1986, § 412(a)(4), 42 U.S.C.A. § 11112(a)(4).

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See publication Words and Phrases for other judicial constructions and definitions.

Appeals from the United States District Court for the Middle District of Florida.

Before TJOFLAT, Chief Judge, DUBINA, Circuit Judge, and DYER, Senior Circuit Judge.

TJOFLAT, Chief Judge:

In this case, a Florida hospital, after completing a lengthy internal disciplinary process, terminated the clinical staff privileges of a staff physician. The physician sued the hospital, alleging various state and federal causes of action and seeking money damages. After an eleven-day trial, a federal jury concluded that the hospital had revoked the physician's staff privileges in violation of its bylaws and awarded the physician nearly $4.2 million in damages for breach of contract. The hospital appeals that judgment as well as the district court's denial of its post-trial motion for judgment as a matter of law, which contended that the hospital was immune from liability in money damages under the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §§ 11101-11152 (1988 & Supp. IV 1992), and under Florida law, Fla. Stat.Ann. § 395.0193(5) (West 1993). Because we conclude that the hospital was entitled to protection from monetary liability under HCQIA, we reverse.

I.

Peer review, the process by which physicians and hospitals

evaluate and discipline staff doctors, has become an integral component of the health care system in the United States. Congress enacted the Health Care Quality Improvement Act to encourage such peer review activities, "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.Rep. No. 903, 99th Cong., 2d Sess. 2, *reprinted in* 1986 U.S.C.C.A.N. 6287, 6384, 6384 *[sic]*. Congressional findings, recited in the text of the statute itself, note that "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State," 42 U.S.C. § 11101(l), and that these problems "can be remedied through effective professional peer review," *id.* § 11101(3). In furtherance of this goal, HCQIA grants limited immunity, in suits brought by disciplined physicians, from liability for money damages to those who participate in professional peer review activities. *Id.* § 11111(a).

Prior to the passage of HCQIA, the specter of litigation seriously impeded the development and vigorous enforcement of hospital peer review procedures. Congress found that "[t]he threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." *Id.* § 11101(4).[1] Accordingly, HCQIA provides that, if a "profes-

[1] *See also* H.R.Rep. No. 903, at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385 (noting that "[e]ven though defendants may often win these lawsuits, that may not be sufficient to guarantee enthusiastic, or even minimally

sional review action" (as defined in the statute) meets certain due process and fairness requirements, then those participating in such a review process shall not be liable under any state or federal law for damages for the results. *Id.* § 11111(a)(1). Thus, "[d]octors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of [HCQIA] are protected from damages sought by a disciplined doctor." H.R.Rep. 903, at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385.

HCQIA is designed to facilitate the frank exchange of information among professionals conducting peer review inquiries without the fear of reprisals in civil lawsuits.[2] The

adequate, peer review" because "[doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review").

[2] In another set of provisions, HCQIA requires health care entities to report certain specific disciplinary actions taken against a staff physician (or the acceptance of a resignation or suspension in return for not conducting investigations or disciplinary proceedings) to a national clearinghouse established to collect and disseminate information on health care providers. 42 U.S.C. §§ 11133-34. Then, prior to admitting a physician to its staff, a hospital must obtain that physician's records from the clearinghouse. *Id.* § 11135. These reporting requirements were designed to "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." *Id.* § 11101(2) (reciting congressional findings). Congress recognized that physicians faced with disciplinary action, no longer able to hide their previous discipline, would feel compelled to challenge any action taken against them in the courts. *See* H.R.Rep. No. 903, at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385. Accordingly, the reporting requirements increased the need to protect peer

statute attempts to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action; accordingly, Congress granted immunity from monetary damages to participants in properly conducted peer review proceedings while preserving causes of action for injunctive or declaratory relief for aggrieved physicians. Because the statutory scheme is somewhat convoluted, we discuss the immunity provisions in detail.[3]

review participants from liability.

The Secretary of Health and Human Services may, following an investigation, publish in the Federal Register the name of a health care entity that has failed to comply with these reporting requirements; a hospital so identified then loses the protection of HCQIA immunity provisions for three years. 42 U.S.C. § 11111(b).

[3] It is important to note that we use the term "immunity" here in a limited sense. *See* H.R.Rep. No. 903, at 3, *printed in* 1986 U.S.C.C.A.N. at 6385. HCQIA establishes an immunity only from liability for money damages, not a right to avoid standing trial. As the Tenth Circuit has concluded, "[t]he plain meaning of [42 U.S.C. § 11111(a)(1)] is that professional review bodies and covered individuals who satisfy the requirements of § 11112(a) are immune from liability only. On its face, the provision does not explicitly establish immunity from suit." *Decker v. IHC Hosps., Inc.*, 982 F.2d 433, 436 (10th Cir.1992) (footnote omitted) (holding that motions to dismiss based on HCQIA immunity are not immediately appealable), *cert. denied*, --- U.S. ---, 113 S.Ct. 3041, 125 L.Ed.2d 727 (1993); *accord Manion v. Evans*, 986 F.2d 1036, 1042 (6th Cir.1993).

This reading of the statute comports with the legislative history surrounding its adoption. According to the report of the House Committee on Energy and Commerce:

Initially, the Committee considered establishing a very broad protection

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The provision of HCQIA that limits the availability of damages for professional review actions provides as follows:

> If a professional review action (as defined in . . . this title) of a professional review body meets all the standards specified in section 11112(a) of this title, . . .
>
> (A) the professional review body,
>
> (B) any person acting as a member or staff to the body,
>
> (C) any person under a contract or other formal agreement with the body, and
>
> (D) any person who participates with or assists the body with respect to the action,
>
> shall not be liable in damages under any law of the United States or of any State (or Political subdivision thereof) with respect to the action.

from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill.

H.R.Rep. No. 903, at 9, *reprinted in* 1986 U.S.C.C.A.N. at 6391.

42 U.S.C. § 11111(a)(1).[4] The standards that professional review actions must satisfy to entitle the participants to such protection are enumerated in section 11112(a) as follows:

> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken--
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted

[4] Section 11111(a)(1) expressly excludes from its coverage suits brought under 42 U.S.C. § 1983 or Title VII of the Civil Rights Act of 1964, but it clearly *does* apply to antitrust claims. *See Patrick v. Burget*, 486 U.S. 94, 105 n. 8, 108 S.Ct. 1658, 1665 n. 8, 100 L.Ed.2d 83 (1988). The section states, however, that [n]othing in this paragraph shall prevent the United States or Attorney General of a State from bringing an action, including an action under [section 4C of the Clayton Act, 15 U.S.C. § 15C], where such an action is otherwise authorized." 42 U.S.C. § 11111(a)(1). And HCQIA "does not restrict the rights of physicians who are disciplined to bring private causes of action for injunctive or declaratory relief." H.R.Rep. No. 903, at 9, *reprinted in* 1986 U.S.C.C.A.N. at 6391.

by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

Id. § 11112(a). Importantly, HCQIA also creates a rebuttable presumption of immunity: "A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence." *Id.*

Section 11112(b) of HCQIA then enumerates the minimum, or "safe harbor" procedures that will, in every case, satisfy the adequate notice and hearing requirement of section 11112(a)(3). *Id.* § 11112(b). Organized in the form of a detailed checklist, the provision defines what hospitals conducting peer review disciplinary procedures must do to obtain the Act's protection for itself and the members of its peer review bodies. We discuss this checklist in more detail *infra* in part III. Congress was careful to explain, however, that "[a] Professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section." *Id.*

The legislative history of section 11112(a) indicates that the statute's reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard. As the House Committee on Energy and Commerce explained:

> Initially, the Committee considered a "good faith" standard for professional review actions. In response to

> concerns that "good faith" might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional review action, the Committee changed to a more objective "reasonable belief" standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.

H.R.Rep. No. 903, at 10, *printed in* 1986 U.S.C.C.A.N. at 6392-93. *See Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir.1992) (holding that HCQIA reasonableness requirements create an objective standard, rather than a good faith requirement).

A review of the facts of this case reveal that HCQIA's limitations on monetary liability dictate the outcome of this appeal.

II.

The appellant, Holmes Regional Medical Center ("Holmes" or "the Hospital"), is a nonprofit corporation operating a private hospital in Melbourne, Florida. The appellee, Dr. Floyd T. Bryan, is a board-certified physician who specializes in general and vascular surgery.[5] Bryan became a member of

[5] The appellees are Bryan and his professional organization, Floyd T. Bryan, M.D., P.A. We refer to them collectively as "Bryan" for convenience.

the Holmes medical staff in 1976; he is generally acknowledged to be an excellent surgeon, often undertaking long, detailed vascular procedures that other physicians in the field avoid. Bryan also has a reputation for being a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who regularly viewed it as his obligation to criticize staff members at Holmes for perceived incompetence or inefficiency. Hospital employees, however, often viewed Bryan's "constructive criticism" as verbal --or even physical-- abuse. Because the Holmes board of directors found Bryan's behavior inappropriate and unprofessional, it terminated his medical staff privileges in November 1990. The means by which Holmes accomplished this termination is the subject of the dispute in this case.

A.

The organizational structure at Holmes, as is the case at most hospitals, is bifurcated, reflecting the distinct roles of the Hospital Administration and of the medical staff. Holmes is governed by a board of directors, comprised mostly of non-physicians, that retains the ultimate responsibility for the operation of the facility. The board employs a staff, led by a president and chief executive officer ("CEO"), to manage the hospital on a day-to-day basis. The medical staff organization, which consists of all doctors with privileges to practice at Holmes, represents the physicians in the Hospital's government. The medical staff is led by an elected chief of staff who presides over the medical executive committee, which comprises the chairpersons of the various clinical departments as well as several officers elected by the staff at large.

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The Holmes board of directors promulgates bylaws for the medical staff, by which all physicians receiving staff privileges at the Hospital agree to be bound. The bylaws provide a detailed series of procedures for handling physician disciplinary actions. Under those bylaws, the medical staff, through its executive committee, may recommend that the board of directors suspend or revoke the privileges of a physician". Although the board retains the ultimate authority over staff privileges, the recommendations of the medical staff are given considerable weight. This system, which is known as peer review, is designed to raise the quality of medical care by encouraging physicians to police themselves. Florida law mandates that hospitals provide for peer review of their staff doctors.[6]

Under the Holmes bylaws, certain hospital officials may request an executive committee investigation[7] into a physician's conduct if the medical staff member fails to comply with the ethics of the medical profession or with the Hospital's bylaws, or if "the Staff appointee is unable to work harmoniously with others to the extent that it affects the orderly operation of the hospital or Medical Staff

[6] *See* Fla.Stat.Ann. § 395.0193(2) (West 1993) ("Each licensed [health care] facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility.").

[7] Investigations may be requested, according to the bylaws, by various officers of the medical staff, including the chairpersons of *various committees* and clinical departments. Such requests must be made in writing to the executive committee and must refer to the specific conduct that constitutes the basis for the request.

organization." Grounds for investigation also include questions regarding a physician's clinical competence or his care and treatment of patients.

Once an investigation is initiated, the executive committee is charged with making a recommendation to the board of directors concerning the level of discipline that should be imposed.[8] The executive committee's recommendation may range from a written warning to revocation of clinical privileges, but a recommendation involving the reduction, suspension, or revocation of clinical privileges entitles the physician to the extensive procedural hearing rights outlined in the bylaws. The executive committee's recommendation is forwarded to the CEO of the hospital, who notifies the physician under scrutiny. The physician has twenty days from receipt of the notice to make a written request for a hearing. If the physician waives his or her right to a hearing, the CEO forwards the recommendation (along with the supporting documentation) to the board of directors for a final disposition

[8] All or part of the physician's privileges may be suspended temporarily pending the outcome of the inquiry. The relevant provision of the bylaws provides:

> At any time during the investigation, the Executive Committee or the Medical Staff President or his designee may suspend all or any part of the clinical privileges of the individual being investigated. This suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall be in effect during the investigation only, shall not indicate the truth of the charges, and shall remain in force, without appeal, during the course of the investigation.

of the matter.[9]

When a physician requests a formal hearing, the executive committee appoints a hearing panel consisting of seven members of the medical staff who have not taken active part in consideration of the matter contested; mere knowledge of the matter does not preclude a staff member from serving on a hearing panel. According to the bylaws, "[t]he purpose of the hearing shall be to recommend a course of action to those acting for the hospital.... [T]he duties of the Hearing Panel shall be so defined and so carried out."

The medical staff bylaws contain detailed procedures governing the hearing process, including provisions for written notice of the time and place for the hearing, prompt scheduling, and lists of witnesses. The physician requesting the hearing is entitled to representation, and has full rights of cross-examination and confrontation of witnesses. The executive committee designates someone, who may be an attorney, to present the disciplinary recommendation that led

[9] The procedure is slightly different when the executive committee settles on a less severe form of discipline. If the action of the executive committee does not involve the reduction, suspension, or revocation of staff privileges, the bylaws provide that "it shall take effect immediately without action of, and without the right of appeal to the Board." A report of the action is sent to the board, which may modify the executive committee's decision on its own initiative. Should the board decide to reject a favorable recommendation by the executive committee and impose a more severe form of discipline that involves the suspension or revocation of clinical privileges, however, the physician would then be entitled to a hearing (according to the same procedures) before the board enters a final decision.

to the hearing and to examine witnesses. In addition, the CEO appoints a hearing officer, who must be an attorney, to preside over the hearing and to rule on the admissibility of evidence; the hearing officer must not act as a prosecuting officer or as an advocate for the hospital. The bylaws recognize that all members of the hearing panel, as practicing physicians, cannot be present for all panel sessions and expressly provide that their absence will not disqualify them or invalidate the hearing.

The decision of the hearing panel is to be based on the evidence produced at the hearing, whether in the form of oral testimony of witnesses or documentary evidence. The bylaws specifically provide that the evidence may include "any material contained in the hospital's files regarding the [complained-against physician] who requested the hearing so long as this material has been admitted into evidence at the hearing and the [physician] who requested the hearing had the opportunity to comment on and, by other evidence, refute it." The "burden of proof" is established as follows: "[T]he Hearing Panel shall recommend against the [physician] who requested the hearing unless it finds that said [physician] has proved that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded."

After reaching a decision, the hearing panel is to "render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made...." The report is then forwarded to the executive committee for whatever modification, if any, it may wish to make in its original recommendation. The executive committee's decision on modification is purely discretionary.

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Within fifteen days after the affected physician is notified of final adverse action by the executive committee, the doctor may make a written request for appellate review by the board of directors. If appellate review is not requested within the fifteen-day period, the affected individual is deemed to have accepted the recommendation involved "and it shall thereupon become final and immediately effective." The terms of the bylaws limit the grounds upon which an adverse disciplinary recommendation may be appealed to the following:

[1] there was substantial failure on the part of the Executive Committee or Hearing Panel to comply with the hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing, or

[2] the recommendation was made arbitrarily, capriciously, or with prejudice; or

[3] the recommendation of the Executive Committee or Hearing Panel was not supported by the evidence.

Under time constraints imposed by the bylaws, the chairman of the board appoints a board review panel (consisting of three or more persons, including board members or "reputable persons outside the hospital") to consider the record upon which the disciplinary recommendation was made. The review panel may accept additional evidence, subject to the same procedural guarantees that apply to hearing panels, and both sides have an opportunity to present arguments. The review

panel then recommends action to the full board.[10]

The board of directors may affirm, modify, or reverse the recommendations of either the appellate review panel or the executive committee, or, in its discretion, refer the matter for further review and, recommendation.[11] When made, the board's ultimate decision is final, immediately effective, and is not subject to further review under the bylaws.

B.

Bryan's disciplinary problems began shortly after he arrived at Holmes in 1976, and they continued throughout his tenure at the Hospital. Indeed, prior to his termination, Bryan was the subject of more than fifty written incident reports involving unprofessional or disruptive behavior, usually complaints regarding Bryan's abusive treatment of nurses, technicians, and even fellow physicians.[12] By December 1987, nurses in the

[10] If the board's review panel recommends action to the board that is contrary to the recommendation of the medical staff, and if a physician's privileges are at Issue, then the matter is first reviewed by a joint conference committee, comprised of members of the board and the medical staff, before the board makes a final decision.

[11] The medical staff bylaw that contains this provision does not indicate to whom the board may "refer the matter for further review."

[12] Some insight into the origins of this behavior came from Bryan himself during his testimony at trial. Shortly after completing his residency, Bryan obtained staff privileges at a Veterans Administration hospital in Miami. There, he explained, he soon learned that the hospital could not fire incompetent nurses and other technicians easily; the most

intensive care unit at Holmes were refusing to care for Bryan's patients on anything but a rotating basis for fear of becoming the object of his volcanic temper. For their part, surgical nurses complained that Bryan's verbal abuse compounded an already stressful environment, precluding them from operating at peak performance.

At trial in this case, numerous employees who had either witnessed or suffered his outbursts described Bryan's temperament; he was characterized as being "brutal" and sharp" with subordinates, as engendering fear in the nursing staff, and as promoting a tense working atmosphere. Bryan admitted both during the Holmes disciplinary process and at trial in federal court that he had a problem with his temper and that his behavior had, at times, been "disruptive" and "unprofessional." He also conceded that the incident reports describing his behavior were not fabrications.

At first, the Hospital and the medical staff attempted to deal with Bryan's behavior informally. Bryan's conduct was the subject of periodic meetings and counseling by the executive committee, the chief of the medical staff, and even the CEO of the hospital. The Hospital repeatedly warned Bryan that his confrontations with staff members could not be tolerated and insisted that he correct his disruptive behavior. In 1985, Bryan agreed to take a voluntary leave of absence and to seek counseling, first with his priest and then with a psychiatrist (who prescribed a number of medications) to control his

effective way to avoid working with nurses he viewed as incompetent or inefficient, he discovered, was to insult them until they refused to participate in operations involving his patients.

temper.

The incidents continued unabated, however, over the next three years, and Hospital officials gradually began to take a more active approach in dealing with the problem. In August 1987, a group of three Holmes officials--the Hospital's CEO, the chief of the medical staff, and the chairman of the department of surgery--advised Bryan that he would be brought before the executive committee for consideration of formal disciplinary action if further incidents occurred. Following additional incident reports detailing a continued behavioral pattern, the executive committee appointed an ad hoc committee "to investigate Dr. Bryan's long term pattern of behavior and look into rehabilitative possibilities and make a recommendation to the Executive Committee." In March, the ad hoc committee recommended that any future problems be the subject of graduated suspensions, beginning with a one-week suspension for the next significant incident. The executive committee agreed to this proposal and informed Bryan in writing of its decision that any further incidents would result in disciplinary action of increasing severity. According to the minutes from the executive committee's March 14, 1988, meeting, "[tlhe Committee felt that such specific guidelines would be an appropriate mechanism to help Dr. Bryan improve his behavior." Bryan did not contest this action.

In April 1988, Just one month after the executive committee's warning concerning graduated discipline, Bryan had an angry exchange with two anesthesiologists when an operation began three minutes behind schedule. When the anesthesiologists attempted to explain why they were taking a few minutes to reexamine the patient's medical records before

administering the anesthesia to the patient on the operating table, Bryan told them that he "didn't give a damn about incompetent people's excuses." According to the anesthesiologists, he then launched into a tirade of insults in loud and angry tones in front of the still-conscious patient.

The executive committee recommended a one-week suspension as a result of the incident with the anesthesiologists; Bryan again accepted the punishment without objection. Yet Bryan's problems with his colleagues continued. In October 1988, for example, Bryan falsely reported to a nurse supervisor that one of her patients had just hanged himself in his room; in fact, the patient was fine. At trial, Bryan explained that he had intended the episode as a "joke" to teach the nurse "responsibility." After additional incidents during the fail of 1988, the executive committee met to consider disciplinary action. Bryan was invited to this meeting, but he did not appear because, due to a miscommunication, he was waiting in his office to be called. The executive committee reviewed the recent incident reports and, concluding that they included at least two new significant episodes, recommended a four-week suspension.[13]

At this point, Bryan for the first time invoked his procedural rights under the bylaws, requesting that a peer review hearing panel evaluate the executive committee's recommendation. Bryan was represented by counsel at the proceedings, over which Dr. Dale Ryon presided. The Ryon panel concluded

[13] Under the bylaws, Bryan's presence was not required at this stage of the proceedings.

that Bryan had in fact done the things alleged and that Bryan's actions were inappropriate. Nevertheless, it recommended that no suspension be imposed. In its report, the panel expressed concern that the subcommittee monitoring Bryan's behavior had not discussed the incident reports with Bryan before making a recommendation to the executive committee, and that the executive committee had recommended a four-week suspension without hearing from Bryan (as a result of the misunderstanding about the meeting). Further, the Ryon panel suggested that the Hospital's incident report system as a whole was flawed because a report might be filed without the affected individual having a contemporaneous opportunity to respond.[14]

After receiving the Ryon panel's report, the executive committee modified its original disciplinary recommendation, reducing the suggested suspension from four weeks to two. Bryan appealed the executive committee's recommendation to the board of directors, which decided that no suspension would be imposed. On October 19, 1989, however, the board advised Bryan by letter that his abusive behavior could no longer be tolerated and that any further incidents of unprofessional behavior would result in the permanent revocation of his staff privileges. Bryan acknowledged the board's conditions by signing this "ultimatum" letter on December 19, 1989. Above his signature, however, Bryan referred the board to his letter of December 13, in which he disputed that his behavior was disruptive and stated that, by signing the board's letter, he was

[14] In response to this criticism, the incident report system at Holmes was changed to ensure that copies of all incident reports would be provided to the subject soon after they were filed.

not waiving his "rights to due process of law or other civil tights as a medical staff member and American citizen."

Despite the board's warning, Bryan was involved in four additional incidents in the first five months of 1990; these four incidents led directly to the termination of Bryan's medical staff privileges. First, surgical technologist Tina Stark filed an incident report stating that, on March 7, Bryan slapped her hands--apparently as a reprimand for a perceived mistake in handling a catheter--while she was assisting him in an operation. On April 9 and 16, 1990, the executive committee held meetings concerning the Stark incident and interviewed the various nurses and physicians who witnessed the events. Given Bryan's past pattern of conduct, the executive committee recommended that Bryan's privileges be suspended for two weeks. Bryan requested a peer review hearing. Before a hearing panel could be appointed, however, Bryan was involved in a second physical incident. On May 16, 1990, while nurse Michael Greene assisted Bryan on an operation, Bryan struck Greene's hands with a surgical instrument; Greene claimed that his hand hurt for several minutes afterwards.

During the same period, Bryan twice ordered the wrong patient prepared for surgery, first in March of 1990 and then in May. On both occasions, the mistake was caught by another physician after the patient had been transferred to the surgical intensive care unit in advance of the operation.

On May 29, 1990, the executive committee convened to

interview the witnesses to the four recent incidents.[15] Bryan presented his version of events to the committee: He attributed what were perceived as slaps to the hands of the nurses as a form of "nonverbal communication" (the use of hand motions by a physician to give directions during surgery) to correct the nurses' mistakes; similarly, although he admitted the misdirections of the patients for surgery, he minimized these mistakes because they were detected in time and no harm had come to the individuals involved. After considering these latest incidents in light of Bryan's history of disruptive behavior and the hospital's varied attempts to correct such behavior--as well as the board's explicit warning a few months before that further unprofessional conduct would result in Bryan's dismissal--the executive committee recommended that Bryan's staff privileges be permanently revoked.

Once again, Bryan requested that a peer review hearing panel be appointed. Chaired by Dr. Joseph Chanda, the panel consisted of seven physicians, none of whom were vascular surgeons.[16] The Chanda panel held four sessions of hearings;

[15] By letter dated May 18, 1990, Dr. Barry Mills, the chief of the medical staff, suspended Bryan's clinical privileges pending an investigation into these matters. This suspension was considered administrative in nature; under the bylaws, Bryan was allowed to continue to care for patients already admitted to the Hospital, but he could not admit any additional patients.

[16] The hearing panel members were appointed by Dr. Mills with the approval of the executive committee. Bryan challenged the initial composition of the panel, alleging bias on the part of Dr. William Broussard, who advised Bryan to seek counseling for his interpersonal problems in 1982. Bryan also contended that the panel should be composed solely of

Bryan was represented by counsel at the proceedings, and he had both the opportunity to cross-examine the witnesses offered by the medical staff and to present witnesses and documentary evidence on his own behalf. A court reporter recorded the testimony at all of the hearing sessions. Two panel members were absent from at least part of the hearings, but Chanda testified at @ that the panel as a whole reviewed the testimony orally at the end of each session and during deliberations and that summarized what had transpired for the absent members.

The Chanda panel heard the testimony of a number of witnesses, including those directly involved in the four most recent incidents. Bryan himself testified as well, explaining that all of his actions at the Hospital had been motivated by his concern for the care of his patients. The panel also considered the earlier incident reports in Bryan's file that had formed the basis for the board's warning to that any additional disruptive behavior would result in the termination of Bryan's privileges.[17]

surgeons. In response to Bryan's objections, Mills selected a new panel member to replace Broussard but did not remove the non-surgeons who had previously been named. As provided by the bylaws, none of the panel members were vascular surgeons (Bryan's direct economic competitors). Bryan did not object to the reconstituted hearing panel.

[17] During the Chanda panel proceedings, the medical staff attempted to introduce all of the prior incident reports involving Bryan's behavior to demonstrate the pattern of misconduct that had led to the board's warning regarding termination of privileges. The hearing officer refused to admit those reports into evidence. On the last day of the proceedings, however, Bryan called Dr. Ryon to testify regarding the earlier incident reports that

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Much of Bryan's defense was focused on a disparate treatment argument. Bryan contended that he had been written up for minor incidents that would have been ignored had they involved any other doctor on the Holmes staff. Bryan also argued that his temper was not disruptive, and that many other physicians at the Hospital had similar or worse temper problems. He further suggested that the disciplinary action was motivated principally by personal animosity on the part of hospital administrators and executive committee members.

After considering the evidence presented, the Chanda panel unanimously found that the most recent incidents, which prompted the executive committee's investigation and disciplinary recommendation, "were amply supported by the record" and violated the admonitions in the board's October 19, 1989, "warning" letter. The panel also concluded that Bryan had demonstrated a pattern of disruptive behavior extending over many years. Because "the hospital behavior of [Bryan was] below acceptable standards and adversely impact[ed] upon patient care and adversely affect[ed] Hospital Staff's ability to deliver quality patient care," the panel rec-

his panel had considered; Bryan attempted to elicit testimony that there was no pattern of inappropriate conduct by Bryan. Because Bryan had brought the earlier incident reports into issue, the Chanda panel asked the hearing officer *sua sponte* to review the reports, which he allowed at the last session of the hearings. Although Bryan complained that the reports should not be reviewed at that late stage of the proceedings, he did not formally object, assert a violation of the Hospital's bylaws, or ask to reopen the hearing to present evidence in rebuttal. Several Holmes officials who testified at trial agreed that Bryan could have requested a postponement to prepare a response if he was concerned about these last-minute developments.

ommended that Bryan's clinical privileges be suspended for two years.

After considering the Chanda panel's report, the executive committee stood by its recommendation that Bryan's staff privileges be revoked. Bryan appealed the executive committee's recommendation to the board of the directors; pursuant to the bylaws, the board appointed a board review panel, which also recommended revocation of Bryan's clinical privileges. The full board then considered the three recommendations--the report of the executive committee recommending termination of Bryan's clinical privileges, the report of the Chanda panel recommending that Bryan be suspended for two years, and the report of the board's own review panel recommending termination.[18] In November 1990, the board unanimously voted to terminate Bryan's clinical privileges at Holmes. Members of the executive committee and the board who testified at trial agreed that the

[18] Bryan has repeatedly emphasized that the board members did not themselves read the complete transcript of the Chanda panel proceedings before reaching the decision to terminate Bryan's privileges. Bryan, however, had the opportunity to obtain a copy of the transcript of the hearings so that he could refer to specific portions in presenting his appeal to the board; he did not do so. Nor does the record indicate that he claimed *at the time* that the bylaws required the board to obtain the transcript before taking action concerning his staff privileges. Moreover, the text of the relevant medical staff bylaw provision states only that "[tlhe Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such a reporter shall be borne by the hospital." A transcript of the first day of the Chanda panel hearings was prepared at Bryan's request and was available for the board's consideration.

disciplinary action was taken after a reasonable effort to obtain the facts and in the reasonable belief that the severe sanction was imposed on Bryan in furtherance of quality patient care at Holmes.

Throughout the disciplinary process, neither Bryan nor the expert witnesses who testified on his behalf contended that the various incident reports that formed the basis for the disciplinary action were fraudulent fabrications. Indeed, Bryan himself admitted that, in each instance, some sort of interaction occurred between himself and the author of the incident report. Bryan merely disagreed both with the Hospital's judgment concerning the propriety of his conduct and the severity of the sanction imposed.

C.

On December 5, 1990, in the United States District Court for the Middle District of Florida, Bryan filed a complaint on behalf of himself and his professional association against the Hospital, the individual members of its board of directors, members of the medical staff executive committee, and two nurses. The complaint included federal and state antitrust claims as well as state law claims for defamation, negligent supervision of the peer review process (against only the individual members of the board of directors), and breach of contract for failing to follow the medical staff bylaws during the disciplinary process (against the Hospital).[19] The

[19]. The complaint also included the following various ancillary claims: (1) constitutional and civil rights claims under 42 U.S.C. § 1983 (1988); (2) federal contractual claims arising out of the Hospital's participation in

complaint demanded damages and, only with respect to the count of negligent supervision, injunctive relief. The central allegation in the complaint was that the defendants, "individually and in concert, acted in bad faith and with intentional fraud, resulting in the destruction of Dr. Bryan's medical practice."

Beginning with their answer denying liability on all counts, the Hospital and the other defendants consistently claimed immunity from monetary liability for their actions in terminating Bryan's clinical privileges because they were functioning in this matter, individually and collectively, as a professional review body in a peer review process. Later, the defendants filed motions for summary judgment, contending, *inter alia* that they were immune from Bryan's suit for damages under HCQIA, 42 U.S.C. § 11111(a), and under Florida law, Fla.Stat.Ann. § 395.0193(5).[20]

the Medicare program; and (3) claims of "interference with prospective economic advantage" and intentional infliction of emotional distress. These causes of action did not figure prominently in the litigation of this case, and the court disposed of these claims either on summary judgment or by granting a directed verdict in favor of the defendants. Because these claims are not before us on appeal, we do not discuss them further in this opinion.

[20]. For the text of the relevant HCQIA provisions, see *supra* part I. The Florida statute requiring that hospitals institute peer review procedures also provides legal protection to participants. The Florida law provides:

> There shall be no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, employees, or any other person for any action taken without intentional fraud in

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In disposing of the defendants' motions, the district court made the following rulings. First, material issues of fact remained concerning whether the applicable standards for peer review actions had been met; therefore, a jury would have to decide the question of immunity. Second, Bryan lacked standing to pursue antitrust claims for damages under either Florida antitrust law or section 4 of the Clayton Act, 15 U.S.C. § 15(a) (1988),[21] but Bryan could assert a claim for injunctive relief under sections 1 and 2 of the Sherman Act, *Id.* §§ 1, 2 (Supp. IV 1993). The factual issues underpinning Bryan's eligibility for injunctive relief would be submitted to the jury, acting in an advisory role. Third, the record did not support Bryan's negligent supervision claim against the individual members of the board of directors. In sum, the following claims remained for trial: the state law damages claims for breach of contract and defamation, as well as the section 1 and 2 Sherman Act claims as to which the jury's verdict would be advisory.

carrying out the provisions of this section.
Fla.Stat.Ann. § 395.0193(5).

[21] This circuit applies a two-pronged test of antitrust standing: The court must first determine that the plaintiff has suffered "'antitrust injury'" and then decide whether the plaintiff is "an efficient enforcer of the antitrust laws." *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1449 (11th Cir.1991). The district court held that Bryan had failed to demonstrate that he was an efficient antitrust enforcer.

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This case was tried before a jury in June 1992.[22] At the close of Bryan's case, the district court directed a verdict in favor of all of the individual defendants on the various counts against them because the evidence was insufficient to support liability. The court concluded, however, that the evidence supported Bryan's claims for breach of contract against the Hospital, and denied the Hospital's motion for a directed verdict because material issues of fact remained concerning the federal and state peer review immunity statutes. The court also found that the evidence supported Bryan's antitrust claims against the Hospital and accordingly submitted those claims to the jury.

While the court's oral jury instructions recited some of the language from the immunity statutes, the court did not explain to the jury that the immunity provisions created a threshold question concerning whether Bryan was entitled to damages at

[22] At trial, as before the Chanda panel, Bryan presented testimony from various expert witnesses explaining that Bryan's actions were proper and did not adversely affect patient care; nothing in the record, they testified, would justify the revocation of Bryan's clinical privileges. This testimony was discounted by the Chanda panel. The experts themselves acknowledged at trial that a pattern of disruptive behavior could become so severe that disciplinary action would be required; on cross-examination, the experts also admitted that they had not examined all of the information considered by the Chanda panel. The Hospital also countered with expert testimony explaining why termination of Bryan's privileges was consistent with sound hospital administration.

Bryan also presented the testimony of witnesses who found fault with the Hospital's peer review procedures, particularly that a transcript of the Chanda panel hearings was not prepared for the board's use and that the Chanda hearing officer had become too inquisitorial in his questioning.

all. Moreover, despite requests by counsel for Holmes, the special verdict form did not include any reference to the federal and state peer review immunity statutes.[23] Regarding the breach of contract claim, the special verdict form simply asked the jury to answer this question: "Did Holmes Regional Medical Center permanently terminate Dr. Bryan's medical staff privileges in violation of its bylaws?" If the jury answered "Yes," the verdict form then directed it to quantify the damages sustained by Bryan as a proximate result of the Hospital's conduct. Similarly, regarding the antitrust claim, the verdict form only asked the jury "[h]as Holmes violated state and federal antitrust laws?"

The jury returned affirmative answers to the verdict form interrogatories regarding whether the Hospital had terminated Bryan in violation of the bylaws and whether this breach proximately caused damages to Bryan; and awarded Bryan $4,181,242 in damages for these violations. The jury also found that the Hospital had violated state and federal antitrust laws, thereby causing harm to Bryan; but the district court denied Bryan's post-trial request for injunctive relief under the antitrust laws, concluding that Bryan's remedy at law was

[23] The following colloquy occurred during the brief charge conference after the court informed counsel of its intended instructions:

> [COUNSEL FOR HOLMES]: [T]he special verdict as read does not include any of the immunity issues. Based on your decision on the directed verdict you've left the decision to the jury and we would respectfully request that the jury be instructed on the immunities.
>
> THE COURT: I think that would be confusing to the jury, that's why I left them out. Of course, you can use that in your argument.

adequate.

The Hospital appeals from the district court's judgment awarding Bryan damages for the termination of his medical staff privileges. Holmes first contends that the district court erred in failing to grant its motion for judgment on the state law damages claim based on immunity from liability under both state and federal laws governing the peer review process. In the alternative, the Hospital argues that a new trial is required because the trial court gave erroneous jury instructions and used an improper special verdict form. Bryan cross-appeals from the portion of the district courts summary judgment order denying the plaintiffs standing to seek damages under federal antitrust law.

III.

A.

[1-3] HCQIA immunity is a question of law for the court to decide and may be resolved whenever the record in a particular case becomes sufficiently developed.[24] Congress

[24] As the House Committee explained:

> The provisions would allow a court to make a determination that the defendant has or has not met the standards specified in section [11112(a)]. The Committee intends that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of litigation that the defendant has met the [section 11112(a)] standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on

clearly intended HCQIA to permit defendants in suits arising out of peer review disciplinary decisions to file motions to resolve the issues concerning immunity from monetary liability as early as possible in the litigation process.[25] As the House Committee explained, "these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible." H.R.Rep. No. 903, at 12, *reprinted in* 1986 U.S.C.C.A.N. at 6394. Several courts have resolved the issue of HCQIA immunity from damages liability on summary judgment. *See, e.g., Harris v. Bellin Memorial Hosp.*, 13 F.3d 1082, 1083 (7th Cir.1994); *Austin*, 979 F.2d at 734-35; *Islami v. Covenant Medical Center, Inc.*, 822 F.Supp. 1361, 1376-77 (N.D.Iowa 1992). Of course, although immunity may be determined at the summary judgment stage, resolution of that issue may be deferred until or after trial if the standards of Rule 56 cannot be satisfied. The substantive standards under

immunity. In such a case, the court could still proceed to determine whether injunctive, declaratory, or other relief would be in order.

H.R.Rep. No. 903, at 12, *reprinted in* 1996 U.S.C.C.A.N. at 6394; *see also Austin*, 979 F.2d at 734 & n. 5.

[25] The American Medical Association, appearing as amicus curiae in the case, urged this position on the court:

> Under the HCQIA, the vast majority of lawsuits challenging peer review proceedings should be dismissed at the summary judgment stage. Suits against peer reviewers should be allowed to go forward only when the plaintiff has rebutted the presumption that the peer review proceeding was reasonable and fair. Any lesser standard would deter physicians from serving as peer reviewers and would therefore undermine the purpose of the HCQIA.

HCQIA, remain the same regardless of the point at which the immunity determination occurs.

[4, 5] In civil rights cases brought under 42 U.S.C. § 1983 (1988), we have held that qualified immunity should not become a part of the jury instruction once the affirmative defense has been denied on a motion for summary judgment; the defense of qualified immunity should be decided by the court and should not be submitted for decision by the jury.[26] We conclude that the same procedure should be followed when considering a defendant's immunity from damages liability under HCQIA. A district court should consider the issue of HCQIA immunity from damages at the summary judgment stage. If it determines that the defendant is not entitled to such

[26] The qualified immunity analysis in suits against government officials under 42 U.S.C. § 1983 provides a useful comparison. Although qualified immunity for government officials is a broader protection than that provided to peer review participants under HCQIA, the proper treatment of the two protections is substantially similar.

In qualified immunity cases, the favored approach is to have the immunity determination made by the court, prior to trial, whenever possible. *See Mitchell v. Forsyth*, 472 U.S. 511, 526, 103 S.Ct. 2806, 2815, 86 L.Ed.2d 411 (1985) (recognizing, of course, that qualified immunity is "an *immunity from suit* rather than a mere defense to liability [that] is effectively lost if a case is erroneously permitted to go to trial"). When the issue cannot be resolved on summary judgment, we have held that "a jury should seldom, if ever, be instructed on qualified immunity; the availability of a qualified immunity defense is a question of law for the court to determine." *Ansley v. Heinrich*, 925 F.2d 1339, 1341 (11th Cir.1991). Accordingly, "[a]lthough the district court preferably makes this determination before trial, qualified immunity is a legal determination that must be made by the court and may be made either before trial, during trial, or after trial." *Stone v. Peacock*, 968 F.2d 1163, 1165 (11th Cir.1992).

protection, then the merits of the case should be submitted to the jury without reference to the immunity issue. If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether the disciplined physician was given adequate notice of the charges and the appropriate opportunity to be heard, the court may ask the jury to resolve the subsidiary factual questions by responding to special interrogatories. *Cf Stone*, 968 P.2d at 1166 (similar framework for section 1983 qualified immunity cases); *see also Islami* 822 F.Supp. at 1378 (following *Stone* framework in HCQIA case). Under no circumstances should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury.

In this case, we review the district court's denial of the Hospital's motion for judgment as a matter of law under Rule 50(b) of the Federal Rules of Civil Procedure.[27] Like the district court in ruling on the motion for judgment, we view all of the evidence in the light most to the non-moving party. It is well established that "[j]udgment as a matter of law after the verdict may be granted only when, without weighing the credibility of the evidence, there can be but one reasonable conclusion as to the proper judgment." 5A Moore's Federal Practice ¶ 50.07[2] (1994). Accordingly, "we must independently determine whether the facts and inferences point so

[27] The Hospital had moved for judgment as a matter of law (for a directed verdict) under Rule 50(a) at the close of Bryan's case and again at the close of all the evidence. The court denied both motions, rejecting the Hospital's assertion of immunity from monetary liability under the federal and state statutes. The issue, therefore, was properly preserved for a post-trial motion for judgment.

overwhelmingly in favor of the movant . . . that reasonable people could not arrive at a contrary verdict." *Roboserve, Ltd. v. Tom's Foods, Inc.*, 940 F.2d 1441, 1448 (11th Cir.1991). Moreover, "[t]he moving party is entitled to a [judgment as a matter of law] if the nonmoving party failed to make a showing on an essential element of his case with respect to which he had the burden of proof." *Smith v. United States*, 894 F.2d 1549, 1552 (11th Cir.1990) (citing *Cetotex Corp. v. Catrett*, 477 U.S. 317, 322-28, 106 S.Ct. 2548, 2552, 91 L.Ed.2d 265 (1986)).

[6] As the Ninth Circuit has explained, the rebuttable presumption of HCQIA section 11112(a) creates an unusual summary judgment standard that can best be expressed as follows: "Might a reasonable jury, viewing the facts in the best light for [the plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?"[28] *Austin*, 979 F.2d at 734. If not, the court should grant the defendant's motion. In a sense, the presumption language in HCQIA means that the plaintiff bears the burden of proving that the peer review process was *not* reasonable. Of course, motions for summary judgment under Rule 56 bear a close relationship to motions for judgment as a matter of law under Rule 50. Courts frequently apply the same standards when ruling on the two motions, although a motion for judgment as a matter of law may be granted although a prior motion for summary judgment

[28]. As the Supreme Court has explained, "in ruling on a motion for summary judgment, the judge must view the evidence presented through the prism of the substantive evidence burden." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254, 106 S.Ct. 2505, 2513, 91 L.Ed.2d 202 (1986).

raising the same issues had been denied. Therefore, we adopt the Ninth Circuit's statement of the applicable standard in this case as well: "[O]ur inquiry focuses on whether [Bryan] provided sufficient evidence to permit a jury to find that he ha[d] overcome, by a preponderance of the evidence, the presumption that [the Hospital] would reasonably have believed" that it had met the standards of section 11112(a). *Austin*, 979 F.2d at 734.

[7] If a jury returns a verdict awarding damages to a disciplined physician but the evidence at trial conclusively demonstrates that the defendant has satisfied HCQIA standards for peer review procedures (thereby being entitled to immunity from monetary liability), then the court should grant a post-trial judgment as a matter of law under Rule 50(b). We must examine the record in this case to determine whether Bryan satisfied his burden of producing evidence that would allow a reasonable jury to conclude that the Hospital's peer review disciplinary process failed to meet the standards of HCQIA.

B.

[8] Before determining whether the procedural standards for proper peer review proceedings were satisfied in this case, we first note that the events and entities at issue here fall squarely within the definitions of HCQIA's operative terms. The disciplinary action at issue here is the November 1990 decision by the Holmes board of directors to revoke Bryan's staff privileges. The term "professional review action" is defined in HCQIA as follows:

[A]n action or recommendation of a professional review

> body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges . . . of the physician.

42 U.S.C. § 11151(9).[29] The revocation of Bryan's staff privileges therefore qualifies as such a professional review action; the statute seems to contemplate inclusion of the recommendations upon which the board's ultimate decision was based--here, the recommendations of the Chanda panel and the executive committee--within the scope of the relevant conduct.

[9] A "professional review body" is defined as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." *Id.* § 11151(11). Furthermore, the term "health care

[29] While its meaning is generally apparent, the statute does provide the following definition of "professional review activity":

> [A]n activity of a health care entity with respect to an individual physician--
>
> (A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
>
> (B) to determine the scope or conditions of such privileges or membership, or
>
> (C) to change or modify such privileges or membership.

42 U.S.C. § 11151(10). Again, the termination of Bryan's medical staff privileges clearly falls within HCQIA definition.

entity" includes "a hospital that is licensed to provide health care services by the State in which it is located." *Id.* § 11151(4)(A)(i). The Holmes decisionmakers in Bryan's case fall within those categories. As a result, the Hospital is entitled to immunity from monetary liability under section 11111(a) of HCQIA if the peer review process met the standards set forth in section 11112(a).

C.

[10] As stated above, a professional review action must satisfy the four standards of section 11112(a) in order to qualify for the immunity protections of section 11111(a). We discuss each in turn and conclude that the Hospital's termination of Bryan's clinical privileges met HCQIA requirements.

1.

[11] First, a review of the record makes clear that the decision to terminate Bryan's clinical privileges at Holmes was taken "in the reasonable belief that the action was in the furtherance of quality health care." *Id.* § 11112(a)(1). This prong of the HCQIA immunity test is met if "the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." H.R.Rep. No. 903, at 10, *reprinted in* 1986 U.S.C.C.A.N. at 6293. The record in this case reveals that the revocation of Bryan's privileges was prompted by the reasonable belief that doing so would promote quality health care. Bryan had exhibited a pattern of unprofessional conduct

over a period of many years, and he was given a series of opportunities to remedy his difficulties in interacting with other staff members. Eventually, the Hospital concluded that, because of his behavior, Bryan's presence in the operating room and in patient rooms was disruptive and interfered with the important work of other employees. Moreover, the board was properly concerned about the circumstances surrounding the misdirection of the two patients to surgery. Accordingly, the Hospital dealt appropriately with the perceived situation in terminating Bryan's privileges.

At trial, Bryan asserted that the members of the board of directors and the executive committee were primarily motivated by personal animosity and not by concern for patient care. He introduced no evidence, however, that such hostility determined the outcome of the peer review process. Moreover, Bryan's "assertions of hostility do not support his position [that the Hospital is not entitled to the HCQIA's protections] because they are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial. The real issue is the sufficiency of the basis for the [Hospital's] actions." *Austin*, 979 F.2d at 734. We therefore conclude that Bryan failed to provide sufficient evidence to permit a jury to find that he had overcome, by a preponderance of the evidence, the presumption that the Hospital's disciplinary action was taken in the reasonable belief that it would further quality patient care.

2.

[12] Second, a review of the record reveals that the Holmes board of directors took its action "after a reasonable effort to

obtain the facts of the matter." 42 U.S.C. § 11112(a)(2). The board terminated Bryan's medical staff privileges only after Bryan's conduct had been evaluated by the executive committee, the Chanda peer review panel, and an appellate review panel of board members. Each of those groups submitted reports to the board, which made its decision based upon the documentary record developed during the various peer review proceedings and after Bryan had the opportunity, to make a presentation. Bryan introduced no competent evidence at trial to suggest that the Hospital's efforts to obtain the facts before terminating his staff privileges were not reasonable.

3.

[13] Third, Bryan's staff privileges were revoked only "after adequate notice and hearing procedures [were] afforded to the physician involved or after such other procedures as [were] fair to the physician under the circumstances." *Id.* § 11112(a)(3). As noted above, section 11112(b) sets forth the "safe harbor" conditions that a health care entity must meet regarding adequate notice and hearing. Section 11112(b) provides as follows:

> A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
>
> (1) Notice of proposed action

The physician has been given notice stating--

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under

paragraph (1)(B)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who am appointed by the entity and are not in direct competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the

hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing, and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

Id. § 11112(b).

As the summary of the facts of the case in part II of this opinion reflects, each of these procedural requirements of section 11112(b) was satisfied. Documents introduced at trial indicate that the Hospital complied with the notice requirements and that the hearings were hold in a timely fashion and in accordance with the Hospital's bylaws. Bryan was afforded full rights of representation, cross-examination, and confrontation.

Bryan's principal argument is that the board of directors did not have a transcript of the Chanda panel hearings when it rendered its decision. Yet HCQIA, like the Holmes bylaws, requires only that the Hospital ensure that a record of the proceedings be made; Bryan had the responsibility to request

a complete transcript if he thought the board should have one, and he did not.

It should be noted that section 11112(b) specifically provides that the failure of a review body to meet the enumerated conditions does not, per se, constitute a failure to meet the standards of section 11112(a)(3). Indeed, "[i]f other procedures are followed, but are not precisely of the character spelled out in (section 11112(b)], the test of 'adequacy' may still be met under other prevailing law." H.R.Rep. No. 903, at 10, *reprinted in* 1986 U.S.C.C.A.N. at 6393. Moreover, Bryan made no contemporaneous objections to the manner in which the hearing procedures were conducted; section 11112(b) explicitly provides that compliance with its terms is not required if the physician voluntarily waives them. On the record of this cue, we conclude that no reasonable jury could conclude that the Hospital had not afforded Bryan the adequate procedures.

4.

[14] Finally, there is no question that the board decided to terminate Bryan "in the reasonable belief that the action was warranted by the facts known." 42 U.S.C. § 11112(a)(4). Again, the record reveals that the board certainly had a factual basis for its action. Bryan concedes that the incidents that led to his termination actually occurred; his only argument is that they did not justify the severe sanction he received. HCQIA clearly grants broad discretion to hospital boards with regard to staff privileges decisions. Accordingly, as in all procedural due process cases, the role of federal courts "on review of such actions is not to substitute our judgment for that of the

hospitals governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges." *Shahawy v. Harrison*, 875 F.2d 1529, 1533 (11th Cir.1989). No reasonable jury could conclude that Bryan had demonstrated, by a preponderance of the evidence, that the Hospital board did not act in the "reasonable belief that the [termination] was warranted by the facts known after reasonable effort to obtain facts" as required by section 11112(a)(4). 42 U.S.C. § 11112(a)(4).

IV.

In this case, a disciplined physician attempted to have a jury revisit the adverse decision of his medical colleagues. This is precisely the type of case that Congress targeted when passing HCQIA: "[T]he intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise." *Mahmoodian v. United Hosp. Ctr., Inc.*, 185 W.Va. 59, 404 S.E.2d 750, 756, *cert denied*, -- U.S. --, 112 S.Ct. 185, 116 L.Ed.2d 146 (1991).

Given that all of the section 11112(a) standards were satisfied, we conclude that the Hospital was entitled to the immunity from damages liability granted by HCQIA in § 11111(a).[30] On the record developed at trial, Bryan could not

[30] Because our holding on this point disposes of all of the claims in the case, we need not reach the question of whether the Hospital was protected from monetary liability under the Florida peer review statute, Fla.Stat.Ann. § 395-0115(5). Bryan has not appealed the district court's refusal to grant

recover the damages awarded by the jury. The district court therefore should have granted the Hospital's post-trial motion for judgment as a matter of law under Rule 50(b). Accordingly, we REVERSE the judgment of the district court denying the Hospital's motion for judgment as a matter of law.

IT IS SO ORDERED.

injunctive relief under the antitrust laws, thus we need not address the merits of the antitrust causes of action.

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

FLOYD T. BRYAN & FLOYD T.,
BRYAN, M.D., P.A.,

Plaintiffs,

v. CASE NO. 90-0896-CIV-ORL-18

JAMES E. HOLMES REGIONAL,
MEDICAL CENTER a/k/a HOLMES
REGIONAL MEDICAL CENTER, INC.,
& OTHERS,

Defendants.
_____/

ORDER

In this action, plaintiffs allege federal and state claims based on James E. Holmes Regional Medical Center's (HRMC) permanent revocation of Floyd T. Bryan, M.D.'s staff privileges. Defendants filed motions to dismiss and for summary judgment. Plaintiffs filed a response in opposition to defendants' motions. Based on a review of the case file and the relevant law, the court DENIES the motion to dismiss and GRANTS, in part, and DENIES, in part, defendants' motions for summary judgment.

I. FACTS

On January 1, 1978, HRMC advised Dr. Bryan of his

appointment to HRMC's active medical staff. (Means Aff., Ex. 1.) Dr. Bryan practiced general and vascular surgery. The parties do not dispute Dr. Bryan's competence in his field of medicine. From 1978 through 1990, Dr. Bryan verbally corrected staff members for actions that he believed endangered patients' lives and submitted numerous letters to HRMC's administration both criticizing and commending staff members. During this time, defendants Raymond A. Armstrong, M.D.; Michael J. Foley, M.D. and Joseph A. Gurri, M.D. also practiced general and vascular surgery at HRMC. Dr. Foley stopped practicing medicine in 1985. Dr. Armstrong, as Chairman of HRMC's Department of Surgery, oversaw the department and recommended corrective actions. Dr. Foley, as HRMC's Medical Director, investigated and reported incidents of concern. Dr. Gurri, as President of HRMC's Medical Staff from 1988 to 1989, oversaw the departments and recommended corrective actions. The evidence suggests that Drs. Armstrong, Foley and Gurri disliked the greater amount of time and money Dr. Bryan spent on surgery, (Ayers Dep. at 36-40), and an HRMC nurse stated that in her opinion they held grudges against Dr. Bryan because of professional jealousy. (Ayers Dep. at 41, 70-71.)

Between 1978 and 1987, HRMC received approximately twenty-five written complaints and incident reports concerning Dr. Bryan's allegedly disruptive behavior. (Means Aff., Composite Ex. 2.) During that period, the HRMC Executive Committee of the Medical Staff (Executive Committee) advised Dr. Bryan that his behavior was unacceptable and might result in temporary or permanent disciplinary action. Dr. Armstrong and defendants Barry A. Mills, M.D.; Lyle Saltzman, M.D.; Lynn Stoldt, R.N.; and Rita Wheeler, R.N., were voting members and Dr. Foley was a non-voting member of the Executive Committee.

Throughout 1987, HRMC continued to receive incident

reports concerning Dr. Bryan's behavior. (Means Aff., Exs. 5-11.) In March 1988, based on the Executive Committee's recommendations, the vice president of HRMC's medical staff sent Dr. Bryan a letter advising Dr. Bryan that he would be subjected to a graduated disciplinary structure. (Means Aff., Ex. 12.) In April 1988, HRMC received an incident report that Dr. Bryan erupted in "a demeaning and profane tirade" against two anesthesiologists. (Means Aff., Ex. 13.) The record shows that problems existed between Dr. Bryan and the anesthesiologist department which Dr. Saltzman headed. (Sullivan Dep. at 218; Ayers Dep. at 33.) HRMC notified Dr. Bryan of the incident report (Means Aff., Ex. 14.) and Dr. Bryan requested an Executive Committee review of the incident. The Executive Committee recommended a seven-day suspension of Dr. Bryan's privileges for his conduct and HRMC's president notified Dr. Bryan of the suspension and his right to appeal it. (Means Aff., Exs. 15, 16.) Dr. Bryan did not appeal the suspension.

In August 1988, HRMC sent Dr. Bryan notice of two additional incident reports concerning his behavior. (Means Aff., Ex. 19.) On November 21, 1988, HRMC's Board of Directors (Board) approved the Executive Committee's recommendation that the Board reappoint Dr. Bryan to the medical staff for one year as opposed to the two year period that Dr. Bryan received in 1986. (Means Aff., Ex. 21.) Dr. Armstrong and defendants Richard N. Baney, M.D.; Michael V. Gatto; Mrs. James E. Gray, III; Martin W. Isenman, M.D.; Maj. Gen. David M. Jones; Michael F. Maguire; Fred L. McFarlin; John E. Miller, M.D.; Val M. Steele; Russell P. Sullivan, Jr.; and John F. Turner, Jr. were members of the Board.

In December 1988, the Executive Committee recommended a four-week suspension based on Dr. Bryan's continued "disruptive behavior" and an incident involving

"inappropriate" progress notes. (Means Aff., Ex. 22.) Dr. Bryan requested an appeal of the suspension. (Means Aff., Ex. 23.) Before the appeal hearing began, HRMC received three more incident reports concerning Dr. Bryan's conduct and gave Dr. Bryan the opportunity to respond to the reports by written comments to the Executive Committee. (Means Aff., Ex. 24.) In May 1989, Dr. Bryan and the Executive Committee presented testimony to a panel of physicians (1989 Panel). In its report, the 1989 Panel did not condone Dr. Bryan's actions. However, the 1989 Panel concluded that Dr. Bryan had already received sufficient punishment without the four-week suspension and criticized the Executive Committee's failure to follow proper incident report review procedures. (Means Aff., Ex. 25.) After reviewing the 1989 Panel report, the Executive Committee recommended a two-week suspension. (Means Aff., Ex. 26.) Dr. Bryan requested an appeal and an opportunity to present oral argument to a board review panel. Based on the 1989 Panel report and oral arguments, the Board Review Panel recommended that the Board of Directors not impose the temporary suspension. The Board Review Panel recommended instead that the Executive Committee monitor Dr. Bryan's behavior and that the Board send Dr. Bryan notice that further display of unprofessional conduct would result in permanent suspension. (Means Aff., Ex. 28) The Board accepted the Board Review Panel's recommendations and sent Dr. Bryan a letter detailing the Board's position. (Means Aff., Ex. 29.)

In March 1990, HRMC advised Dr. Bryan of two incident reports concerning his behavior. The first report stated that Dr. Bryan slapped a nurse's hand and the second report stated that Dr. Bryan misdirected a patient for surgery. At Dr. Bryan's request, the Executive Committee scheduled a meeting to review the first incident report. (Means Aff., Exs. 33, 34.) At the Executive Committee meeting, Dr. Bryan and

the nursing personnel involved with the report gave conflicting versions of the incident. (Means Aff., Ex. 35.) The Executive Committee called a special meeting for further investigation. At the special meeting, the Executive Committee conducted additional interviews and concluded that the incident was not of great significance. The Executive Committee recommended, however, a two-week suspension of Dr. Bryan's privileges based on his history of disruptive behavior. (Means Aff., Ex. 36.) On April 24, 1990, the president of HRMC notified Dr. Bryan of the two-week suspension and his right to appeal and request a hearing. (Means Aff., Ex. 38.)

Before Dr. Bryan received a hearing on the Executive Committee's action, HRMC received two more incident reports concerning Dr. Bryan's behavior. One report stated that Dr. Bryan struck an operating room nurse with a surgical instrument and the other involved a misdirected patient. The Executive Committee interviewed Dr. Bryan and the staff involved with the incidents. Drs. Gurri, Foley and Armstrong and HRMC's president commented about the long-term problems with Dr. Bryan and the Board's mandate to monitor Dr. Bryan's actions. Based on its finding of an escalation of Dr. Bryan's problems with the hospital staff and concern for patient welfare, the Executive Committee imposed a summary suspension of Dr. Bryan's privileges and recommended a permanent revocation of Dr. Bryan's privileges. (Means Aff., Ex. 41.)

In response, Dr. Bryan requested a hearing by a panel of his peers (1990 Panel). (Means Aff., Ex. 43.) At the 1990 Panel hearing, Dr. Bryan's counsel presented witnesses and evidence and cross-examined HRMC's witnesses. (Means Aff., Composite Ex. 48.) The 1990 Panel deliberated the issue and concluded that the record supported the Executive Committee's recommendations. The 1990 Panel also found that Dr. Bryan had a pattern of disruptive behavior that was

below acceptable standards and adversely affected the hospital staff's ability to deliver quality patient care. Based on their findings, the 1990 Panel recommended that the Board suspend Dr. Bryan's privileges for two years. (Means Aff., Ex. 49.) The Executive Committee reviewed the 1990 Panel's findings but voted not to modify its original recommendations. (Means Aff., Ex. 51.)

At Dr. Bryan's counsel's request, a board review panel heard oral argument and reviewed the 1990 Panel record. (Means Aff., Ex. 52.) The Board Review Panel recommended that the Board adopt the Executive Committee's recommendation of permanent revocation. (Means Aff., Ex. 53.) The Board voted to affirm the Board Review Panel's recommendation and informed Dr. Bryan of its decision. (Means Aff., Ex 55.) The chairman of the Board testified that the Board adopted the Executive Committee's recommendation over that of the 1990 Panel because the Board placed more trust in the Executive Committee's judgment. (Sullivan Depo. at 54-62.) The chairman also stated that he had no knowledge that Dr. Bryan's conduct jeopardized or injured any patient. (Sullivan Dep. at 119.) A nurse testified that other doctors at HRMC lost their tempers with the staff; used non-verbal communications in the operation room, such as striking a nurse with an instrument; and misdirected patients, but was unaware of HRMC revoking any other doctors' privileges for such conduct. (Ayers Dep. 14, 27, 58, 61-62, 71-72.) The nurse also testified that superiors on the nursing staff singled out Dr. Bryan when they instructed members of the nursing staff to write incident reports and document them. (Ayers Dep. at 49-50.)

HRMC's president notified the Division of Medical Quality Assurance of the Department of Professional Regulation of the State of Florida that HRMC had permanently suspended Dr. Bryan's privileges and its reasons for taking

such action. (Means Aff., Ex. 56.) The National Practitioner Data Bank also received the information over Dr. Bryan's objections. (Means Aff., Ex. 57.)

II. LEGAL DISCUSSION

A. *Standards of Review*

1. *Motions to Dismiss.*

For purposes of a motion to dismiss, the court must view the allegations of the complaint in the light most favorable to the plaintiff and consider the allegations of the complaint as true. See *Quality Foods de Centro Am. S.A. v. Latin Am. Agribusiness Dev. Corp.*, 711 F.2d 989, 994-95 (11th Cir. 1983). On a motion to dismiss for lack of subject matter jurisdiction, the plaintiff has the burden of showing that he has properly invoked the court's jurisdiction. *Barton v. City of Eustis*, 415 F. Supp. 1355, 1357 (M.D. Fla. 1976).

2. *Motions for Summary Judgment.*

Summary judgment is authorized if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56 (c); *accord Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). "[A]t the summary judgment stage the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson*, 477 U.S. at 249. The moving party bears the burden of proving that no genuine issue of material fact exists. *Celotex Corp. v. Catrett*, 477

U.S. 317, 323 (1986). In determining whether the moving party has satisfied the burden, all inferences drawn from the underlying facts are considered in a light most favorable to the party opposing the motion, and all reasonable doubts are resolved against the moving party. *Anderson*, 477 U.S. at 255; *see Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88 (1986). The non-moving party who bears the burden of proof on the issue at trial must go beyond the pleadings and submit affidavits, depositions, answers to interrogatories, or admissions on file that designate "specific facts showing that there is a genuine issue for trial." *Celotex*, 477 U.S. at 324 (quoting Fed. R. Civ. P. 56(e)).

B. *Motions to Dismiss*

Defendants Mills, Wheeler, Baney, Gatto, Gray, Isenman, Jones, Maguire, McFarlin, Miller, Steele, Sullivan, and Turner (state-only defendants) are parties to plaintiffs' state claims not their federal claims. The state-only defendants filed motions to dismiss plaintiffs' claims against them alleging no federal pendent party jurisdiction. However, 28 U.S.C.A. § 1367 expressly authorizes the exercise of pendent party jurisdiction in any civil action of which the district courts have original jurisdiction, except diversity jurisdiction, to the extent pendent claims form part of the same case and controversy under Article III of the Constitution. 28 U.S.C.A. § 1367. Plaintiffs commenced this action after § 1367 became effective and their complaint asserts federal jurisdiction based on federal statutes, not diversity of citizenship. The state-only defendants do not claim that plaintiffs' federal and state claims arise out of different controversies. Therefore, pursuant to § 1367, plaintiffs' complaint shows that federal jurisdiction exists for plaintiffs' claims against the state-only defendants.

C. *Motions for Summary Judgment*

1. *Immunity*

In their motions for summary judgment, defendants contend that they are immune from plaintiffs' suit for damages under the Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C.A. §§ 11101-11152, and Florida Statutes §§ 395.0115 and 766.101(3)(a). Although plaintiffs do not specifically address the immunity statutes, they point to facts that are relevant to the immunity issue in their opposition to defendants' motions for summary judgment.

(a) *Federal (HCQIA) Immunity.*

HCQIA immunity provides incentive and protection for qualifying professional peer review action bodies and individuals associated with or assisting the professional review action. 42 U.S.C.A. § 11111(a), *Austin v. McNamara*, 731 F. Supp. 934, 939 (C.D. Cal. 1990). To qualify for HCQIA immunity, defendants must demonstrate that their review actions concerning Dr. Bryan complied with the standards set forth in 42 U.S.C.A. § 11112. § 11111(a). To satisfy the § 111112 [*sic*] standards, defendants must show that their review actions were taken (1) in the reasonable belief that their actions were in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing was afforded to Dr. Bryan or after such other procedures as were fair to Dr. Bryan under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the notice and hearing requirements. § 11112(a). A professional review action is presumed to meet the standards unless the presumption is

rebutted by a preponderance of the evidence. *Id.*

In this action, defendants rely on the holding in *Austin* to support their argument that they satisfied the § 11112 standards. In *Austin*, a medical executive committee summarily suspended a doctor's privileges and a judicial review committee conditionally reinstated his privileges based on evidence that the doctor's treatment of a particular patient was substandard and external evaluations indicated that the doctor's conduct created serious concerns in some areas. *Austin*, 731 F. Supp. at 938-40. The doctor filed an antitrust action against the hospital and committee members alleging the defendants conspired to restrain trade and monopolize the market. *Id.* at 934. The *Austin* court granted the committees immunity because the court found that the committees' actions were reasonably warranted by the facts. *Id.* at 940.

Although defendants correctly point to the similarities between *Austin* and this action, they fail to note the distinctions between the two cases. In this action, defendants rely on evidence that hearing panels gathered facts and provided Dr. Bryan with adequate notice and hearings. Yet, defendants disagreed with the hearing panels' recommendations and imposed more severe disciplinary actions against Dr. Bryan. Thus, unlike the committees in *Austin* which relied on their own fact gathering to make their decisions, defendants in this action reviewed the hearing panels' findings but did not adopt the panels' recommendations. Further, unlike the plaintiff in *Austin* who merely alleged a conspiracy with little factual support, plaintiffs attack defendants' reasons for their actions as pretextual and support their claim with evidence that Dr. Bryan's conduct was not the type of conduct that a hospital ordinarily sanctions by revoking a doctor's privileges and the Board had no evidence before it that Dr. Bryan's conduct placed particular patients in danger. Finally, the court recognizes that permanent revocation of a doctor's privileges

is a more serious sanction than a temporary suspension or a conditional reinstatement of privileges. Based on these findings, the court concludes that a question remains whether Dr. Bryan's conduct reasonably warranted the permanent revocation of his privileges.

(b) *State Immunity.*

Under the Florida immunity statutes, defendants are protected from monetary liability if they acted without intentional fraud. Fla. Stat. Ann. §§ 395.0115(5), 766.101(3)(a). Defendants contend that plaintiffs provide no evidence to substantiate their claims of intentional fraud. The record shows, however, that animosity existed between Dr. Bryan and Drs. Armstrong, Foley, Gurri, and Saltzman; nurses singled out Dr. Bryan for incident reports; defendants disregarded the board review panels' recommendations; Dr. Bryan's conduct was not the type of behavior ordinarily subjected to permanent revocation of privileges; and defendants had no evidence that Dr. Bryan's conduct placed a patient [*sic*]. Viewing this evidence in a light most favorable to plaintiffs, the court finds a genuine issue whether defendants acted without intentional fraud.

2. *Count I: Federal Antitrust Claim*

(a) *Standing.*

In Count I of their complaint, plaintiffs bring a private cause of action under sections 4 and 16 of the Clayton Act, 15 U.S.C.A. §§ 15, 26 (West Supp. 1992) against defendants HRMC, Foley, Armstrong and Gurri (antitrust defendants) alleging violations of sections 1 and 2 of the Sherman Act, 15 U.S.C.A. §§ 1, 2. In their motions for summary judgment, the

antitrust defendants challenge plaintiffs' standing under section 4 of the Clayton Act. Plaintiffs did not address the standing issue in their response in opposition to defendants motions for summary judgment.

Standing to bring an antitrust claim is a question of law which the court determines by examining the allegations contained in the complaint. *Todorov v. DCH Healthcare Authority* 921 F.2d 1438, 1448 (11th Cir. 1991). To establish a private right of action under Section 4 of the Clayton Act, the court must determine whether (1) the plaintiff suffered "antitrust injury," and (2) plaintiff is an efficient enforcer of the antitrust laws. *Id.* at 1449. The antitrust defendants allege that plaintiffs fail to satisfy either requirement.

The antitrust defendants claim that plaintiffs lack standing because their complaint asserts that the antitrust defendants' anticompetitive conduct prevents Dr. Bryan from reaping the profits of his share of the market. See *id.* 1450-54 (finding that a doctor lacked standing because the antitrust laws were not intended to permit one person to profit from anticompetitive behavior.). However, because plaintiffs seek competitive profits, *see Id.* at 1452 n. 23 (defining competitive profits as those profits that would be earned when all qualified physicians competed freely), the court finds that their injury derives from some anticompetitive conduct and is the type of injury the antitrust laws were intended to prevent, and thus, qualifies as an antitrust injury. *Contra Robles v. Humana Hosp. Cartersville*, 1992 WL 37642 at *8 (N.D. Ga. 1992) (finding that a doctor failed to allege an antitrust injury, but relying on cases in which courts determined whether the plaintiffs showed an unreasonable restraint on trade as opposed to whether the plaintiffs suffered an antitrust injury).

Even though plaintiffs sufficiently allege an antitrust injury, plaintiffs must also show that they are efficient enforcers of the antitrust laws. To determine whether plaintiffs

are efficient enforcers, the court must look at the directness of the injury, the nature of the injury, the potential for duplicative recovery of damages, and the existence of more direct victims of the alleged antitrust violation who could bring suit. *Todorov*, 921 F.2d at 1450-51. The antitrust defendants contend that patients, insurers, and the government have stronger interests in ensuring that prices and services remain at competitive levels unlike plaintiffs whose interest is in competing. Plaintiffs do not dispute the antitrust defendants' position. Thus, because the antitrust defendants show that more efficient enforcers of the antitrust laws exist, the court finds that plaintiffs lack standing to bring a private action for damages under section 4 of the Clayton Act. *See Robles*, 1992 WL 37641 at *8 (finding that if the defendants are acting anticompetitively and are charging an inflated price or providing inferior services for the same prices; the patients, insurers, and government may bring action to enjoin the defendants' conduct); *see also Todorov*, 921 F.2d at 1455 (finding patients, insurers, and the government constitute a class of persons whose self-interest would motivate them to vindicate the public interest).

Although the antitrust defendants succeed in showing that they are entitled to summary judgment as to plaintiffs' standing to bring an action for damages under section 4 of the Clayton Act, they do not provide grounds for summary judgment as to plaintiffs' standing to bring an action for injunctive relief under section 16 of the Clayton Act. Because courts are less concerned about whether the plaintiff is an efficient enforcer of antitrust laws when the remedy is equitable, *Todorov*, 921 F.2d at 1452; the court's conclusion that plaintiffs lack standing under section 4 because they are not efficient enforcers does not show lack of standing under section 16. Furthermore, because the court finds that plaintiffs sufficiently allege an antitrust injury, plaintiffs' have standing

under section 16. *Cf. id.* at 1454 (holding that the court's finding of no antitrust injury compels the court to conclude that plaintiff has no standing to seek an injunction).

(b) *Conspiracy.*

The antitrust defendants claim that plaintiffs fail to create a genuine issue that a conspiracy existed. To establish a conspiracy, plaintiffs must show that (1) two or more persons (2) conspired to restrain trade or monopolize. *Seagood Trading Corp. v. Jerrico, Inc.*, 924 F.2d 1555, 1573 (11th Cir. 1991); *Todorov*, 921 F.2d. at 1455, 1459. The antitrust defendants argue that HRMC acted unilaterally in its decision to revoke Dr. Bryan's privileges because no conspiracy existed.

Plaintiffs may establish a conspiracy by inferences drawn from the antitrust defendants' behavior but antitrust law limits the range of permissible inferences. *Matsushita*, 475 U.S. at 588; *Todorov*, 921 F.2d at 1456. Further, plaintiffs must show that the inference of conspiracy is reasonable in light of the inferences of independent action. *Matsushita*, 475 U.S. at 588 (holding that plaintiffs bear the burden of presenting evidence that reasonably tends to exclude the possibility that the alleged conspirators acted independently). HRMC claims that it revoked Dr. Bryan's privileges to ensure efficient operation of the hospital, and thus, compete with other hospitals. Because HRMC presents a plausible procompetitive reason for its decision, plaintiffs in this action must satisfy a higher burden of proof. *See Todorov*, 921 F.2d at 1456-58 (finding that a hospital's interest in competing with other hospitals presents a plausible procompetitive reason for its actions, and thus, the plaintiff bears a higher burden of proof).

The antitrust defendants correctly state that plaintiffs'

evidence that doctors in competition with Dr. Bryan recommended that HRMC revoke Dr. Bryan's privileges and that HRMC relied on the doctors' recommendation is insufficient alone to create an inference of conspiracy. See *Todorov*, 921 F.2d at 1458-59. Yet, plaintiffs do not rely solely on the antitrust defendants' opportunity to conspire. Instead, plaintiffs challenge HRMC's reasons for revoking his privileges as pretextual based on evidence that Dr. Bryan's conduct was not the type of conduct that a hospital ordinarily sanctions by revoking a doctor's privileges and the Board had no evidence before it that Dr. Bryan's conduct placed any patient in danger. Because plaintiffs present evidence of pretextual reasons for the antitrust defendants' actions, the court finds that a reasonable jury could find plaintiffs' evidence creates an inference of conspiracy. *See Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 822, 827 (11th Cir. 1990) (holding that evidence of pretextual reasons for a decision can show a conspiracy), *cert. denied*, 110 S. Ct. 1960 (1990).

(c) *Monopoly.*

HRMC contends that it is entitled to summary judgment as to plaintiffs' claim under section 2 of the Sherman Act because HRMC does not compete in the same market as Dr. Bryan. HRMC fails to note that plaintiffs allege that HRMC conspired with Drs. Armstrong, Foley and Gurri who were Dr. Bryan's competitors. Accordingly, the court denies HRMC's motion for summary judgment as to plaintiffs' section 2 claim. *See White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98, 104 (4th Cir. 1987) (implying that one who conspires with a competitor can be held liable as a monopolist in the market); *cf. Beard v. Parkview Hosp.*, 912 F.2d 138, 144 (6th Cir. 1990) (affirming dismissal of claims for monopolization and

attempted monopolization against a defendant hospital because it did not compete with the plaintiff, but not addressing a claim for conspiracy to monopolize); *Bozcar v. Manatee Hosps. & Health Systems, Inc.*, 731 F. Supp. 1042, 1047 (M.D. Fla. 1990) (finding no cause of action for conspiracy to monopolize because the plaintiffs failed to allege that the hospital or the doctors competed in the relevant market).

Defendants Armstrong, Foley and Gurri claim that they are entitled to summary judgment as to plaintiffs' section 2 claim because plaintiffs fail to point to evidence showing a specific intent to monopolize. Defendants Armstrong, Foley and Gurri reason that because they present plausible procompetitive reason for recommending the revocation of Dr. Bryan's privileges, the court cannot infer that they intended to destroy competition or build a monopoly in the relevant market. *See White*, 820 F.2d at 105; *Castelli v. Meadville Medical Ctr.*, 702 F. Supp. 1201, 1208 (W.D. Pa. 1988), *aff'd mem.*, 872 F.2d 411 (3d Cir. 1989). Yet, the court finds that plaintiffs' evidence that the antitrust defendants' legitimate reasons were pretextual, *see supra* section C.2.(b), creates a genuine issue whether defendants Armstrong, Foley and Gurri acted with an intent to monopolize. *Cf. White*, 820 F.2d at 105 (granting summary judgment because plaintiff offered no proof negating legitimate business practices); *Castelli*, 702 F. Supp. at 1208 (granting summary judgment because plaintiff offered no direct or circumstantial evidence of an intent to monopolize).

3. *Count VI: State Antitrust Claim.*

In Count VI, plaintiffs allege that the antitrust defendants violated Florida's antitrust laws. Fla. Stat. ch. 542. Section 542.32 of the Florida Statutes provides authority for construing Florida antitrust laws based on federal courts'

interpretation of comparable federal antitrust statutes. Because Florida's damages provision, closely tracks the language of section 4 of the Clayton Act, the court should find that plaintiffs have no standing to bring a damages claim under Florida antitrust law. *Reitz v. Canon U.S.A., Inc.*, 695 F. Supp. 552, 553 (S.D. Fla. 1988).

4. *Count II: Civil Rights Claim.*

Plaintiffs bring a cause of action under 42 U.S.C. § 1983, alleging that defendants HRMC, Armstrong, Foley, Gurri, Saltzman and Stoldt (civil rights defendants) violated Dr. Bryan's rights to due process and equal protection. Plaintiffs allege that the civil rights defendants acted under the color of state law because (1) HRMC is a non-profit organization operating a general hospital under the laws of Florida, (2) the civil rights defendants receive substantial funds directly or indirectly from the United States government for services rendered to patients eligible under Medicare and Medicaid programs, and thus, are subject to regulation by the United States government under 20 C.F.R. § 405, and (3) HRMC receives substantial federal, state and local tax benefits by virtue of its non-profit status. In their motions for summary judgment, the civil rights defendants claim that plaintiffs' allegations fail to show state action as required by § 1983. Plaintiffs did not respond to the civil rights defendants' arguments.

To establish state action under § 1983, plaintiffs must show that the civil rights defendants' alleged infringement of federal rights is fairly attributable to the state. *Boczar*, 731 F. Supp. at 1045. Courts have found evidence of federal and state funding and tax benefits insufficient to establish state action. *Id.* Further, state regulation does not create state action without evidence that the state coerced or significantly

encouraged the civil rights defendants' actions. *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 164-66 (1978); *Waters v. St. Francis Hosp., Inc.*, 618 F.2d 1105,1107 (5th Cir. 1980); *Boczar*, 731 F. Supp. at 1045. Because plaintiffs present no evidence that the state compelled the civil rights defendants' actions, the court grants summary judgment in favor of the civil rights defendants on Count II. *See Waters*, 618 F.2d at 1107.

5. *Count III: Federal Contract Claim.*

Plaintiffs allege that HRMC breached a contract with the United States government because it failed to comply with federal medicare regulations as provided in 42 U.S.C. §§ 1395-1395ccc [*sic*] (Medicare Act) and 20 C.F.R. § 405.1023. HRMC claims that the Medicare Act does not entitle plaintiffs to a third-party beneficiary action. To bring a private cause of action, plaintiffs must show either express or implied authority in the statute. *Cort v. Ash*, 422 U.S. 66, 68-69 (1975); *see Goldsmith v. Harding Hosp., Inc.*, 762 F. Supp. 187, 188 (S.D. Ohio 1991) (outlining the factors that a court should consider to determine whether a statute implicitly provides a private cause of action).

Plaintiffs provide no grounds for the court to find express or implicit authority in the Medicare Act for plaintiffs to bring a private cause of action. Moreover, HRMC cites caselaw to support its position that a private remedy is not implicit in the Medicare Act. *Robinson v. Magovern*, 456 F. Supp. 1000, 1001 (W.D.Pa. 1978). In addition to finding no implicit private remedy in the Medicare Act, the *Robinson* court noted that § 1395 provides that "nothing in this subchapter shall be construed to authorize any federal officer or employee to exercise any supervision or control over . . . the selection, tenure, or compensation of any officer or

employee of any institution, agency, or person providing health services." *Id.* Because plaintiffs fail to show that the Medicare Act provides either an express or implicit private cause of action, the court grants summary judgment in favor of HRMC on Count III.

6. *Counts VII: Defamation - Slander.*

Plaintiffs allege that Dr. Armstrong is liable for slander because he knowingly and maliciously published false statements about Dr. Bryan. Plaintiffs further allege that defendants Foley, Gurri, Mills, Saltzman, Stoldt and Wheeler (slander defendants) are liable for Dr Armstrong's slanderous statements. Although plaintiffs do not allege that the slander defendants authorized or published false statements about Dr Bryan, plaintiffs evidently rely on their conspiracy allegations to connect the slander defendants with the alleged statements. In their motions for summary judgment, the slander defendants contend that because plaintiffs fail to show a conspiracy, they fail to establish the slander defendants liability The court finds, however, sufficient evidence to create a genuine issue whether a conspiracy exists, and thus, the slander defendants do not provide sufficient grounds for the court to grant summary judgment on Count VIII.

7. *Count X: Negligence*

Plaintiffs allege that defendants Armstrong, Baney, Gatto, Gray, Isenman, Jones, Maguire, McFarlin, Steele, Sullivan and Turner (Board member defendants) are liable for negligent failure to supervise, manage and advise various HRMC committees. Plaintiffs base their negligence claim on the board member defendants' alleged duty to insure that HRMC's committees followed the Medical Staff Bylaws,

Rules and Regulations with the regard to the review of any physician's clinical privileges. Plaintiffs provide no authority for their claim that the Board member defendants owed a duty to Dr Bryan. Moreover, Florida negligence law indicates that the Board owed a duty only to patients. *See Insinga v. LaBella*, 543 So. 2d 209, 214 (Fla 1989) (finding that a hospital owes a duty to patients to assure the competence of medical staff and personnel through its selection and review process); *see also* Fla. Stat. §§ 395.01115(1) [*sic*] (stating that the legislative intent for establishing peer review procedures is to secure quality medical care to Florida citizens), 766.110(1) (establishing hospital liability for failure to exercise due care in fulfilling statutory duties when such failure is the proximate cause of injury to a patient). Therefore, the court finds that plaintiffs fail to establish an essential element of their negligence action, and thus, grants summary judgment on Count X. *See Tieder v. Little*, 502 So. 2d 923, 925 (Fla. Dist. Ct. App. 1987) (holding that to maintain a negligence cause of action, one element that a plaintiff must prove is a duty to conform to a certain standard of conduct for the protection of others, including the plaintiff), *review denied*, 511 So. 2d 298 (Fla 1987).

III. Conclusion

The court finds that federal jurisdiction exists over the state-only defendants pursuant to 28 U.S.C.A. § 1367, and thus, DENIES the state-only defendants' motions to dismiss (Docs. 48, 50) With regard to the motions for summary judgment, the court finds that the undisputed facts, as well as the reasonable inferences drawn from the facts, do not establish a genuine issue of material fact that would justify bringing plaintiffs' civil rights, federal contract, and negligence claims (Counts II, III, X) to trial. Accordingly, the court

GRANTS partial summary judgment in favor of defendants on Counts II, III and X. The court further finds that plaintiffs lack standing to bring a cause of action for damages but are entitled to a claim for injunctive relief under federal and state antitrust laws. Thus, the court GRANTS summary judgment in favor of defendants as to plaintiffs' claim for damages and DENIES summary judgment on their claim for injunctive relief under state and federal antitrust laws. (Counts I, IV) Because genuine issues of fact exits [*sic*] as to defendants right to protection under federal and state immunity statutes and as to plaintiffs' federal and state antitrust, state contract, interference with prospective economic advantage, intentional infliction of emotional distress and defamation claims (Counts I, IV-IX) the court DENIES defendants' motions for summary judgment as to those claims. (Docs. 44, 46, 48, 50) The court GRANTS plaintiffs' motion to strike affidavits and defendants' motion for leave to file amended affidavits. (Docs. 86, 97)

It is SO ORDERED in Orlando, Florida, this 20th day of May 1992.

/s/ G. Kendall Sharp
G. KENDALL SHARP
United States District Judge

Copies to all counsel of record

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

FLOYD T. BRYAN &
FLOYD T. BRYAN, M.D., P.A.

Plaintiffs,

v. CASE NO. 90-0896-CIV-ORL-18

JAMES E. HOLMES REGIONAL
MEDICAL CENTER a/k/a HOLMES
REGIONAL MEDICAL CENTER, INC.,
& OTHERS,

Defendants.
_____/

ORDER

This action is before the court on the parties' post-trial motions. Floyd T. Bryan (Bryan) filed motions for injunctive relief, to amend judgment to include injunctive relief, and for attorneys fees. Holmes Regional Medical Center (HRMC) responded to Bryan's motions. HRMC filed motions for judgment as a matter of law on Bryan's contract claim, for judgment as a matter of law on Bryan's antitrust claims, to correct judgment, for new trial, for remittitur, to strike attorneys fees, and to review taxation of costs. Bryan then filed motions to strike HRMC's post-trial motions, HRMC's motion to review taxation of costs, and HRMC's memoranda in support of its motions for judgments as a matter of law. Bryan also responded in opposition to HRMC's post-trial

motions.

I. Facts

Plaintiffs filed a complaint against defendants which asserted various causes of action allegedly arising out of defendants' participation in terminating Bryan's staff privileges at HRMC. Before and during trial, the court ruled in favor of defendants on each of plaintiffs' causes of action except their causes of action for breach of contract and violation of antitrust laws. As to the contract and antitrust claims, the court found that only HRMC is subject to liability. The court further held that plaintiffs did not have standing to claim damages under the antitrust laws but could seek injunctive relief. Although the complaint included a general request for injunctive relief, it did not specify the type of relief plaintiffs sought.

On June 17, 1992, a jury returned a verdict in favor of plaintiffs. The jury found that HRMC breached its contract with plaintiffs. Plaintiffs requested six million dollars in damages, comprised of approximately one million dollars for loss of past earnings and five million dollars for loss of future earnings. HRMC contested Bryan's damages claim. The jury determined that Bryan's damages amounted to approximately four million dollars.

The jury also found that HRMC violated state and federal antitrust laws and that its violation caused Bryan injury. After the jury rendered its verdict, Bryan submitted a motion for injunctive relief which asks the court to (1) require HRMC to retract its reports to the State Medical Board and the National Practitioners Data Bank (NPDB) which were based on HRMC's illegal revocation of Bryan's privileges; (2) require HRMC to obtain from NPDB a complete list of all entities who received information concerning HRMC's

revocation of Bryan's privileges and to mail the retraction mentioned above to the entities on the list; (3) enjoin HRMC, its officers, agents and employees from continuing to publish reports that Bryan struck, slapped, or hit various members of the operating team and that Bryan is a disruptive or unprofessional physician and from publishing or using any other defamatory language that demeans Bryan's conduct while he practiced at HRMC; and (4) retain jurisdiction to enforce the above provisions.

II. Legal Discussion

A. *Injunctive Relief*

Section 16 of the Clayton Act entitles any person to sue for and obtain injunctive relief against threatened loss or damage by a violation of the antitrust laws under traditional equity principles. 15 U.S.C.A. § 26. Traditional equity principles dictate that injunctive relief is warranted in this action if Bryan shows (1) a violation of the antitrust laws and (2) continuing irreparable harm if an injunction is not issued and a lack of an adequate remedy at law. *See Newman v. State of Alabama*, 683 F.2d 1312, 1319 (11th Cir. 1982), *cert. denied*, 460 U.S. 1083 (1983); *Credit Bureau Reports, Inc. v. Retail Credit Co.*, 476 F.2d 989, 992 (5th Cir. 1973); *see also Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982) (defining the traditional bases for injunctive relief as irreparable jury and inadequate legal remedy). The court must also consider whether the relief requested fulfills the primary purposes of the antitrust laws which courts define as ending illegal conduct, depriving violators of benefits of the conduct, and restoring competition to the marketplace. *See Arthur S. Langenderfer, Inc. v. S.E. Johnson Co.* 729 F.2d 1050, 1059 (6th Cir.), *cert. denied*, 469 U.S. 1036 (1984); *Ohio-Sealy*

Mattress Mfg. Co. v. Sealy, Inc., 669 F.2d 490, 495 (7th Cir.), *cert. denied*, 459 U.S. 943 (1982); *In re Multidistrict Vehicle Air Pollution*, 538 F.2d 231, 234-35 (9th Cir. 1976); *see also Weinberger*, 456 U.S. at 320 (recognizing courts' judicial power to enforce statutes in accord with traditional practices, as conditioned by the public interest which Congress seeks to protect).

Bryan does not seek an injunction to prevent HRMC from continuing its practice of revoking staff privileges in violation of the antitrust laws. Instead, Bryan contends that the relief requested is necessary to eliminate the consequences of HRMC's illegal acts and to ensure that they do not recur. Although courts have recognized Bryan's grounds for relief as types of harm subject to antitrust regulations, *see Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 132 (1969); *Weiss v. York Hosp.*, 745 F.2d 786, 829-30 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); *Paschall v. Kansas City Star Co.*, 695 F.2d 322, 335 (8th Cir. 1982) (citing *United States v. United States Gypsum Co.*, 340 U.S. 76 (1950)), *rev'd on reh'g on other grounds*, 727 F.2d 692 (8th Cir.), *cert. denied*, 469 U.S. 872 (1984), Bryan must also show that he lacks and adequate remedy at law and a significant threat of injury. *Newman*, 683 F.2d at 1319; *Credit Bureau Reports*, 476 F.2d at 992; *Fuchs Sugars & Syrups, Inc. v. Amstar Corp.*, 380 F. Supp. 441, 443 (S.D.N.Y. 1974).

Bryan claims that the professional reports and HRMC's continuing publications will prevent him from obtaining staff privileges at another health care facility. According to Bryan, because the jury awarded him four million dollars rather than six million dollars in damages, the jury did not consider the damage that the professional reports and HRMC's continuing publications would cause to his ability to resume his practice. Although the jury did not award Bryan the entire amount that he requested, based on Bryan's evidence, approximately one

million dollars of the damages requested by Bryan were allocated to loss of past income, and thus, the jury awarded approximately three million dollars in damages for loss of future income. Bryan presents no evidence while calculating the three million dollars in losses of future income, the jury failed to include losses the professional reports and HRMC's continuing publications would create. Furthermore, at the time the jury submitted its verdict, it was unaware of the injunctive relief that Bryan intended to seek. Accordingly, the court finds that Bryan fails to show that his monetary damages do not compensate him for any injury the professional reports and HRMC's continuing publications may cause to his ability to resume his practice.

Even if the jury award did not include monetary damages for future losses arising out of the professional reports and HRMC's continuing publications, Bryan fails to show a significant threat of injury. As to the professional reports, if HRMC fails to amend its reports, Bryan can dispute the accuracy of the reports and, under the NPDB system, the Secretary of the United States Health and Human Services Department will send an amended report to anyone who received the original report concerning Bryan's conduct at HRMC. *See* 45 C.F.R. § 60.14. As to the alleged threat of defamatory statements, although Bryan submitted evidence that HRMC continues to make statements concerning Bryan's conduct at HRMC, the court found similar pre-trial statements insufficient to support a defamation claim. Thus, Bryan fails to show that HRMC's post-trial conduct constitutes a significant threat of injury in the form of defamation.

Finally, the court recognizes that the Seventh Circuit Court of Appeals affirmed a district court order that granted injunctive relief similar to the relief requested in this action. *See Wilk v. American Medical Ass'n*, 895 F.2d 352, 367-68 (7th Cir.), *cert. denied sub nom. Wilk v. Joint Comm. on*

Accreditation of Hosp., 496 U.S. 927 (1990). However, the Seventh Circuit noted that the district court made no findings on the issue whether the plaintiffs had an adequate remedy at law, and thus, the appellate court refused to address the defendant's untimely and poorly developed claim that the plaintiffs had an adequate remedy at law. *Id.* at 370 n.5. Therefore, the holding in *Wilk* does not change the outcome of this action. Because the court finds that Bryan has an adequate remedy at law, the court denies Bryan's motion for injunctive relief and to amend judgment to include injunctive relief.

B. *Other Post-Trial Motions*

Bryan filed a motion to strike all of HRMC's post-trial motions as untimely because Bryan erroneously believed the [*sic*] July 3, 1992 was not a federal holiday. A review of the recognized federal holidays reveals, however, that when July 4 falls on a Saturday, July 3 is a federal holiday. Therefore, because HRMC filed its post-trial motions within ten days of entry of judgment, excluding weekends and federal holidays and allowing three days for service by mail, the court denies Bryan's motion to strike. *See* Fed. R. Civ. P. 6(a), (c); 50(b); 52(a); 59(b).

As to HRMC's motions for judgments as a matter of law, the court grants HRMC's motion to submit supplemental authority in support of its motions. However, even considering HRMC's supplemental authority, the court finds that HRMC fails to show the absence of a legally sufficient basis for a reasonable jury to find in favor of Bryan, and thus, denies HRMC's motions for judgments as a matter of law. *See* Fed. R. Civ. P. 50 (a), (b). Because the court denies HRMC's motions, the court denies as moot Bryan's motion to strike HRMC's memoranda in support of its motions for exceeding

the twenty-page limit.

HRMC claims that it is entitled to a new trial because the jury verdict is not supported by the weight of evidence and because the court committed prejudicial errors. The court finds, however, HRMC fails to support its claims and thus, denies HRMC's motion for a new trial. *See* Fed. R. Civ. P. 59(a).

In its motion for remittitur, HRMC asks the court to reduce the amount of damages awarded by the jury to reflect the impact of the injunctive relief on Bryan's future losses. Because the court denies Bryan's motion for injunctive relief, the court finds no grounds for reducing the amount of damages, and thus, denies HRMC's motion for remittitur.

HRMC asks the court to correct the final judgment entered in favor of the individual defendants on June 22, 1992 to include the court's dismissal of Count VII against HRMC. HRMC correctly observes that the court's directed verdict on Count VII included dismissing plaintiffs' claim against HRMC. Further, a review of the file shows that neither the final judgment dismissing the action against the individual defendants nor the final judgment against HRMC on Bryan's contract and antitrust claims reflect the court's dismissal of Count VII against HRMC. Bryan argues that the court should not amend the final judgment against the individual defendants because HRMC stands in a different position than the individual defendants. Specifically, Bryan notes that the court dismissed the entire action against the individual defendants but dismissed only Count VII against HRMC. Yet, the court entered the final judgment in favor of the individual defendants to account for plaintiffs' claims that were not submitted to the jury. Because plaintiffs' Count VII against HRMC was not submitted to the jury, the court finds that the dismissal of Count VII against HRMC should be included in the final judgment against the individual defendants, and thus, grants

HRMC's motion to correct judgment.

The court defers ruling on the motions concerning taxation of costs and refers the motions involving attorneys fees to the magistrate judge.

III. Conclusion

Because the court finds that Bryan fails to show that he lacks an adequate remedy at law, the court DENIES his motions for injunctive relief and to amend judgment to reflect injunctive relief. (Docs. 189, 190.) The court finds that HRMC filed its post-trial motions within the time allotted by the Federal Rules of Civil Procedure, and thus DENIES Bryan's motions to strike HRMC's post-trial motions and to strike HRMC's motion to review taxation of costs (Docs. 219, 226.) The court GRANTS HRMC's motion to submit supplemental authority (Doc. 232). The court DENIES HRMC's motions for judgments as a matter of law, new trial, and remittitur, (Docs. 198, 201, 203, 205), and DENIES as moot Bryan's motion to strike HRMC's memoranda in support of its motions for judgments as a matter of law. (Doc. 220.) Because the final judgment disposing of all the claims that were not submitted to the jury fails to reflect that the court dismissed Count VII against HRMC on motion for directed verdict, the court GRANTS HRMC's motion to correct judgment. (Doc. 200.) The court DEFERS ruling on the motions concerning taxation of costs, (Docs. 211, 227), and REFERS the motions involving attorneys fees to the magistrate judge. (Docs. 191, 212, 215.)

It is SO ORDERED in Orlando, Florida, this 27 day of August 1992.

/s/ G. Kendall Sharp
G. KENDALL SHARP
United States District Judge

Copies to all counsel of record

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

FLOYD T. BRYAN and
FLOYD T. BRYAN, M.D., P.A.,

Plaintiffs,

vs. Case No. 90-896-CIV-ORL-18

JAMES E. HOLMES REGIONAL
MEDICAL CENTER a/k/a HOLMES
REGIONAL MEDICAL CENTER, INC.,
et al.,

Defendants.

_____/

MOTION FOR JUDGMENT AS A MATTER OF LAW PURSUANT TO RULE 50(b)

Defendant JAMES E. HOLMES REGIONAL MEDICAL CENTER a/k/a HOLMES REGIONAL MEDICAL CENTER, INC. ("Holmes"), by and through its undersigned counsel, moves for entry of judgment as a matter of law against the Plaintiff, FLOYD T. BRYAN ("Bryan") pursuant to Rule 50(b), Fed. R. Civ. P. As grounds therefor, the Holmes states:

1. The jury, by special verdict form, found that Holmes breached the provisions of its bylaws, and that Bryan suffered monetary damages in the amount of $4,181,220.00 as a result of such breach. This Court entered judgment on that

special verdict on June 22, 1992.[1] This verdict does not conform to the requirements of law and is not supported by the evidence. If permitted to stand, the verdict jeopardizes the hospital peer review process which both Congress and the Florida Legislature have endorsed by a grant of presumptive immunity to participants therein. This verdict must therefore must be set aside.

2. Courts and juries are not permitted to substitute their judgment for that of a hospital's governing board. Rather, the limited role of the court and the jury in review of hospital staff decisions is to assure that the requirements imposed by the Board are reasonably related to the operation of the hospital and fairly administered. Shahawy v. Harrison, 875 F.2d 1529, 1533 (11th Cir. 1989). The evidence presented at trial conclusively shows that Holmes' decision to terminate Bryan's staff privileges was reasonably related to the orderly and efficient operation of the hospital and treatment of patients, and that the procedures for disciplinary action adopted in Holmes' bylaws were fairly and properly administered. A grant of judgment to Bryan is therefore not supported by law, and is clearly erroneous.

3. The actions taken by Holmes in the proceedings leading to the termination of Bryan's staff privileges were undisputedly part of the peer review process authorized by

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[1] Holmes interprets the Court's June 22, 1992 Judgment on behalf of Bryan to indicate that this Court has reserved ruling on Bryan's antitrust claims. Holmes has accordingly filed a renewed motion for judgment as a matter of law under Rule 50(a), Fed. R. Civ. P., addressing the antitrust claims. If Holmes is in error, and the June 22, 1992 Judgment addresses both the breach of contract and antitrust claims, Holmes requests that the motion regarding the antitrust issues be considered as part of this motion under Rule 50(b), and that Holmes be permitted to exceed the twenty page limit on memorandum of law imposed by Local Rule 3.01.

§395.0115, Fla. Stat. The Florida Legislature has provided a presumptive grant of immunity from any claims for monetary damages to hospitals and physicians participating in the peer review process authorized by §395.0115(5), Fla. Stat., absent a showing of intention fraud by the Hospital. Section 395.0115(5), Fla. Stat.

4. To prove intentional fraud under Florida law, Bryan is required to prove 1) that Holmes created or induced charges against Bryan that were false; 2) that Holmes knew the charges were false; and 3) that Holmes submitted the false charges against Bryan with the intent that they be relied upon by the members of the Medical Executive Committee, the peer review panels, and the Board. Taylor v. Kenco Chemical and Mfg. Corp., 465 So.2d 581, 589 (Fla. 1st D.C.A. 1985); Barrett v. Guesnel, 90 So.2d 706 (Fla. 1956). Bryan has failed to present any competent evidence to show any of these essential elements necessary to prove intentional fraud on the part of Holmes. A grant of judgment to Bryan therefore violates the requirements of §395.0115(5), Fla. Stat., and is clearly erroneous.

5. Congress has granted immunity from any claims for monetary damages to hospitals and physicians participating in the peer review process by enactment of the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C.A. §11101, et seq. The HCQIA provides a presumption of validity to peer review proceedings that must be overcome by the complaining physician. 42 U.S.C.A. §11111(a); Austin v. McNamara, 731 F.Supp. 934, 942 (C.D. Cal. 1990); Fobbs v. Holy Cross Health Systems Corp, 1992 WL 78727 (E.D. Pa. 1992). The evidence produced at trial conclusively establishes that Holmes' actions in the events and proceedings leading to the termination of Bryan's staff privileges complied with all requirements of the HCQIA. A grant of judgment to Bryan therefore violates the requirements of 42 U.S.C.A. § 11111(a),

and is clearly erroneous.

6. There is no permissible basis to distinguish this action from Austin, and the grant of immunity from any liability for monetary damages afforded to the hospital in Austin under the HCQIA should apply equally to Holmes. Any attempt to distinguish this case on the basis that 1) the disciplinary action adopted by Holmes differed from that of the Chanda Panel; 2) Bryan claims that Holmes' stated reasons for terminating his privileges were pretextual; or 3) the disciplinary action taken by Holmes against Bryan was more severe than the actions taken against Dr. Austin, is not supported by the language of the HCQIA, the legislative history or existing case law.

7. Bryan has failed to offer evidence at trial upon which a reasonable jury could determine that Holmes materially breached the provisions of its bylaws. As recognized by this Court in its May 20, 1992 Order granting summary judgment to Holmes on Bryan's claims under 42 U.S.C.A. §1983, Bryan has no right to challenge the "fairness" of the provisions of the bylaws. He is only entitled to sue for material breach of the provisions of the bylaws to which he agreed to be bound upon his appointment to the staff at Holmes. Lawler v. Eugene Wuestoff Memorial Hospital Assn., 497 So.2d 1261 (Fla. 5th DCA 1989).

8. Even if Bryan were able to prove the minor violations of the bylaws which he claimed occurred, such violations could not be the proximate cause of any injury to Bryan. There is no reasonable basis to conclude that the termination of Bryan's staff privileges was caused by anything other than Bryan's disruptive behavior and the legitimate concerns of Holmes and all other participants in the peer review process for Holmes' staff and patients. A grant of judgment to Bryan is therefore clearly erroneous.

9. Due to the twenty (20) page limitation imposed by

the Local Rules, Holmes cannot address all of the issues which would provide support for this Motion. However, failure to present an issue in this Memorandum shall not be considered as a waiver of the issues for appeal purposes. Holmes reserves the right to fully address any issues omitted herein on appeal.

WHEREFORE, Defendant **JAMES E. HOLMES REGIONAL MEDICAL CENTER a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.** requests that this court enter judgment against Plaintiff **FLOYD T. BRYAN** as a matter of law, in accordance with Rule 50(b), Fed. R. Civ. P.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing and the memorandum of law in support thereof was furnished by U.S. Mail to George H. Moss, Esq., Post Office Box 3406, Vero Beach, FL 32964-3406; Joseph P. Metzger, Esq., 1616 Forum Place, Suite 300, West Palm Beach, FL 33407-2384; and to Larry Klein, Esq., Suite 503, Flagler Center, 501 South Flagler Drive, West Palm Beach, FL 33401 this 7th day of July, 1992.

/S/ Christopher K. Kay

Christopher K . Kay
Florida Bar No. 0385931
Ronald M. Schirtzer
Florida Bar No. 0501662
FOLEY & LARDNER
111 North Orange Avenue, Suite 1800
Post Office Box 2193
Orlando, Florida 32802-2193
(407) 423-7656
Attorneys for the Defendant
JAMES E. HOLMES REGIONAL MEDICAL CENTER a/k/a HOLMES REGIONAL MEDICAL CENTER

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 92-2963

FLOYD T. BRYAN, FLOYD T. BRYAN, M.D., P.A.,

Plaintiffs-Appellees-Cross-Appellants,

versus

JAMES E. HOLMES REGIONAL MEDICAL CENTER, a/k/a Holmes Regional Medical Center, Inc.,

Defendants-Appellant-Cross-Appellee,

RAYMOND A. ARMSTRONG, M.D., Individually and as Chairman, Department of Surgery, HRMC, and as member of the Board of Directors, HRMC, MICHAEL H. FOLEY, M.D., Individually and as Medical Director, HRMC, MICHAEL V. GATTO, Individually and as Member of the Board of Directors, HRMC, JAMES E. GRAY, III, Individually and as Secretary of the Board of Directors, HRMC, JOSEPH A. GURRI, M.D., Individually and as Chief of Medical Staff, HRMC, MARTIN W. ISENMAN, M.D., Individually and as Member of Board of Directors, HRMC, DAVID M. JONES, Maj. Gen., (Retired), Individually and as Treasurer of the Board of Directors, HRMC, MICHAEL F. MAGUIRE, Individually and as Member of the Board of Directors, HRMC,

FRED L. MCFARLIN, Individually and Member of the Board of Directors, HRMC, JOHN E. MILLER, Ph.D., Individually and as Chairman, Executive Committee, HRMC, LYLE SALTZMAN, M.D., Individually and as Member of the Executive Committee, HRMC, VAL M. STEELE, Individually and Member of the Board of Directors, HRMC, LYNN STOLDT, R.N., Individually and Head Operating Nurse, HRMC, RUSSELL P. SULLIVAN, JR., Individually and as Chairman of the Board of Directors, HRMC, JOHN F. TURNER, JR., Individually and First Vice Chairman of Board of Directors, HRMC, RITA WHEELER, R.N., Individually and as Operating Room Supervisor, HRMC,

Defendants.

On Appeal from the United States District Court for the Middle District of Florida

---

ON PETITION(S) FOR REHEARING AND
SUGGESTION(S) OF REHEARING EN BANC

Before: TJOFLAT, Chief Judge, DUBINA, Circuit Judge and DYER, Senior Circuit Judge.

PER CURIAM:

(X) The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

( ) The Petition(s) for Rehearing are DENIED and the Court having been polled at the request of one of the members of the Court and a majority of the Circuit Judges who are in regular active service not having voted in favor of it (rule 35), Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are also DENIED.

( ) A member of the Court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor of it, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/S/ GERALD B. TJOFLAT
CHIEF JUDGE

United States District Court

MIDDLE DISTRICT OF FLORIDA

ORLANDO DIVISION

FLOYD T. BRYAN and
FLOYD T. BRYAN, M.D., P.A.,

v. JUDGMENT IN A CIVIL CASE

JAMES E. HOLMES REGIONAL
MEDICAL CENTER, a/k/a
HOLMES REGIONAL MEDICAL
CENTER, INC. CASE NO: 90-896-Civ-Orl-18

XX **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

Decision by Court. This action came to trial or hearing before the Court. the issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

that the plaintiff, FLOYD T. BRYAN, recover of the defendant, JAMES E. HOLMES REGIONAL MEDICAL CENTER, a/k/a HOLMES REGIONAL MEDICAL CENTER,

INC. the sum of $4,181,242.00 with interest thereon at the rate of 4.26% as provided by law, and his costs of action.

that the plaintiff, FLOYD T. BRYAN, M.D., P.A., take nothing, that the action be dismissed on the merits.

APPROVED FOR ENTRY

/S/ G. KENDALL SHARP
G. KENDALL SHARP
United States District Judge

June 22, 1992
Date

DAVID L. EDWARDS
Clerk

/S/ Darleen G. Darby
(By) Deputy Clerk

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

FLOYD T. BRYAN & FLOYD T. BRYAN, M.D., P.A.

Plaintiffs,

v. CASE NO. 90-0896-CIV-ORL-18

JAMES E. HOLMES REGIONAL MEDICAL CENTER, etc., & OTHERS,

Defendants.
_____/

SPECIAL VERDICT FORM

1. Did Holmes Regional Medical Center permanently terminate Dr. Bryan's medical staff privileges in violation of its by-laws?

Yes _X_ No ___

If your answer to question 1 is no, go to question 4.

2. If your answer to question 1 is yes, did Holmes's conduct proximately cause any injury or damage to Plaintiffs?

Yes _X_ No ___

3. If your answer to question 2 is yes, what is the amount of any actual damages sustained by Plaintiffs as a proximate result of Holmes's conduct?

Floyd T. Bryan: $ 4,181,242.

Floyd T. Bryan, M.D., P.A.: $ 0

4. Has Holmes violated state and federal antitrust laws?

Yes X No ___

If your answer to question 4 is no, date and sign the verdict.

5. If your answer to question 4 is yes, has Holmes's violation of the federal and state antitrust laws been a proximate cause of any injury and/or damages, threatened or actual, to Plaintiffs?

Floyd T. Bryan Yes X No ___

Floyd T. Bryan, M.D., P.A. Yes ___ No X

SO SAY WE ALL this 17 day of June, 1992.

/S/ LELA L. ABRAMS
FOREPERSON

of the situation at the time, they can't control it. And if they're hollering and they're screaming, they're not normally hollering at the nurse or the person in the room, it's the situation at that time that's taking control.

Q. Have you ever in the period of time that you were a nurse at the hospital at Holmes Regional Medical Center seen Dr. Bryan do anything which in your opinion jeopardized the safety of this patients?

A. Never.

Q. Have you ever seen him do anything which in your opinion would justify his losing the right to practice on the staff of Holmes Regional Medical Center?

A. Not to my knowledge, no.

Q. During the period of time that you've known Dr. Bryan, has his behavior changed?

A. Yeah, I think it has in the years.

Q. What's happened to Dr. Bryan other than he's seven or eight years older?
A. I think we have all gotten older and we have all mellowed some.

Q. And when you indicate mellow, does that indicate mellow in relation to his temper?
A. Very much so.

Q. Have you been subjected to temper bouts by other

A. I think I did.

Q. And did you in the hearing hear anything that indicated that Dr. Bryan was, was unable to operate because of bad eyesight?

A. There is a paragraph to that in this letter.

Q. Yes, sir, I know there was in the letter. But did you hear any evidence?

A. No.

Q. And didn't in fact --
A. From witnesses?

Q. Yes, sir, from any witness. Anybody?
A. No.

Q. Or that he had two pending malpractice lawsuits or that his surgical technique or skills were at all in question.
A. On the contrary. I think his surgical skills were always held to the highest.

Q. So during the Ryon panel, that stack that I just showed, to the best of your recollection, did anybody accuse Dr. Bryan of being incompetent or dangerous to his patients?
A. Absolutely not that I recall.

Q. Now, Dr. Teegen, when your committee, after going over I guess the things in this letter that we just discussed, let me hand you number 399, which is

CURRICULUM VITAE

FLOYD TALMADGE BRYAN, M. D.

BIRTHDATE AND PLACE:	May 5, 1939; Henderson, North Carolina
ADDRESS:	521 West River Oaks Drive, Indialantic, Florida, 32903
FAMILY STATUS:	Married; two girls, one grandchild
EDUCATION:	University of North Carolina A.B.(English Literature) 1961
	University of North Carolina School of Medicine M. D. 1966

PROFESSIONAL ACTIVITIES:

1966-67	Surgical Intern, Johns Hopkins Hospital
1967-68	Junior Assistant Resident, Johns Hopkins Hospital
1968-69	Second Year Resident, University of Miami Hospitals (Jackson Memorial amd [*sic*] VA)
1971-72	Third Year Resident, University of Miami Hospitals
1972-73	Chief Resident and Instructor, University of Miami Hospitals

1973-74	Assistant Professor of Surgery, University of Miami School of Medicine
1974-76	Staff Surgeon, U.S. Navy, Naval Regional Medical Center, Great Lakes
1975-76	Clinical Assistant Professor of Surgery Chicago Medical School
1976-90	Staff Surgeon, Holmes Regional Medical Center, Melbourne
1982-85	Secretary, South Brevard Foundation for the Advancement of Medical Care
1988-	Founding Member, Florida Vascular Society
1988-89	Executive Committee, Southern Association for Vascular Surgery
1988-90	Executive Council, Florida Vascular Society
1985-90	Interview Committee, North Florida, American College of Surgeons

FELLOWSHIPS:

1960-61	Fellowship in Research, Department of Pathology, University of North Carolina School of Medicine: Factor VIII Isolation

1963-64	Graduate School, Fellowship in Research, Department of Pathology, University of North Carolina School of Medicine: Phylogenesis of Coagulation
1969-70	Post-graduate course in Cellular and Molecular Biology; Research in vasoactive amines-Bradykinin; University of Miami
1970-71	Medical Unit Laboratory, St. Mary's Hospital, Paddington, Praed St., London, UK: Renovascular Hypertension and Prostaglandins
Jan. 1983	"Mini" Fellowship with Dr. Stanley Crawford, Methodist Hospital, Houston, Texas: Thoracoabdominal Aneurysms

PROFESSIONAL SOCIETIES:

International Society for Cardiovascular Surgery

American College of Surgeons

Southern Association for Vascular Surgery

The Johns Hopkins Surgical Society

Royal Society of Surgeons, Associate

Society of Sigma Xi

Southeastern Surgical Society

Florida Medical Association

Brevard County Medical Society

Jackson Surgical Society

Womack Surgical Society

American Cancer Society

American Heart Association

Association of V. A. Surgeons

Florida Vascular Society,
Founding Member

MILITARY: Commander, MC, USNR, 1974-76

STATE MEDICAL LICENSES:

North Carolina, 1966, #6456

Maryland, 1967 #C11265

Florida, 1973, #19763

HONORS: American Board of Surgery: Special Competency in Vascular Surgery, 1/84, #74

Fellow, American College of Surgeons, 10/78

American Board of Surgery, 10/9/74, #20429

Phi Beta Kappa

Morehead Scholar

Alpha Epsilon Delta

Beta Club - President

Scout - Eagle, God and Country, Order of the Arrow, Vigil

PUBLICATIONS:

1. Bryan, F.T., Ashley, G. and Langdell, R.D.: Studies of Coagulation of blood of the snapping turtle, Fed. Proc. 24" (2), March 1965.

2. Bryan, F.T., Robinson, C., Gilbert, C., and Langdell, R.D.: N-Ethyl maleimide inhibition of Horseshoe Crab hemocyte agglutination, Science, 144: (3622), May 1964.

3. Langdell, R.D., Bryan, F.T., and Gibson, R.: Coagulation of catfish blood, Proc. Soc. Expl. Biol. Med., 118:439, 1965

4. Bryan, F.T., Ryan, J.W., and Niemeyer, R.S.: Bradykininogen synthesis by liver. In: Back and Sicuteri (Eds.), Vasopeptides, Plenum Publishing Company, New York, 1972

5. Bryan, F.T. and Ryan, J.W.: Bradykininogen, Ciencia E. Cultura, Vol. 23, August, 1971

INTERESTS: Family

Surgery

Sailing

Tennis

Fishing

Snorkling

Q. -- as Dr. Bryan?

Does he treat those patients, that is, accept them and operate on them the same way Dr. Bryan does?

A. I don't know. I have had a few cases with Dr. Gurri that were pretty much run of the mill cases, not anything that you would call complicated.

Q. And how about Dr. Armstrong, same question?

A. The same answer. I worked with him on some uncomplicated, fairly straight forward cases.

Q. And then finally to Dr. Bryan, based upon your ability being at the hospital and observing and being there, what type of cases does he take on?

A. Well, I've seen Dr. Bryan take on very difficult cases and very complicated cases, and cases that I guess would be a judgment call as to whether you would take on that case and go to the limits to try and save that patient or try and help that patient. And I think that he, I've observed him use all of his abilities to try and help patients and save patients, and I've seen him do some very good work on some very complicated cases where I've been consulted afterwards.

For example, we had one patient who had a cannon ball go through half of her body.

the question who's working with him today?

A. It was maybe not the question itself; it was the way in which it was said.

Q. I see. And what is disparaging about the question what does he plan on doing today when asking about the kind of surgery that's to be performed?

A. Well, Dr. Bryan was a forerunner in the vascular surgery at Holmes, and he was very innovative with his techniques, and there were a few surgeons who took issue with this.

Q. You indicate -- Do you believe that they're taking issue with this by the fact they're asking what kind of surgery is he going to do today?

A. Yes, yes. Do you understand what I'm saying?

Q. No, ma'am.

A. Okay. Dr. Bryan was one of the first surgeons that did a composite graft. Now, that was part man-made material and part body material. And at that time this was considered very innovative, and it was also an extreme measure, and there were some surgeons who felt that this was not to the benefit of the patient.

Q. Did they tell -- Did those physicians tell you that?

A. Yes.

Q. I see. And who were those physicians?

A. Do you really want me to answer that?

Q. Yes, ma'am.

A. Okay. Dr. Gurri was one of them. Dr. Bryan had a reputation for doing very complex surgeries. He had to use a lot of time. We used very delicate surgery instruments and very delicate suture material, and sometimes it was very hard to see, and it took a great deal of patience to do this. And some doctors, Dr. Gurri among them, did not want to spend that much time to do the procedure.

Q. So Dr. Gurri had a professional opinion that differed from that of Dr. Bryan?

A. Yes.

Q. And yet you call -- Is that a disparaging remark in your opinion?

A. As I said, it was not what was said, it was how it was said.

Q. Is that a difference of opinion in your mind, does that constitute a disparaging remark?
A. Not a difference of opinion, no.

Q. All right. Other than Dr. Gurri, who else in your opinion made disparaging remarks about Dr. Bryan?
A. I'd rather not say.

Q. Well, ma'am, as Mr. Moss indicated, this is a very serious matter.

EXECUTIVE COMMITTEE
February 19, 1988

A special meeting of the Executive Committee was held on Friday, February 19, 1988 in the Executive Board Room.

Those Present Were:

Joseph A. Gurri, M.D.
Barry A. Mills, M.D.
Jack T. Bechtel, M.D.
Lyle Saltzman, M.D.
Scott Z. Seminer, M.D.
C. Mario Oliveira, M.D.
Scott Gettings, M.D.
Raymond A. Armstrong, M.D.
Richard W. Schmid, D.D.S.
Laudie McHenry, M.D.
Paul Miller, M.D.
H. Phillips Stall, M.D.
Michael J. Foley, M.D.

The purpose of the meeting was to review recent incident reports concerning the behavior of Dr. Floyd Bryan.

Dr. Gurri stepped down as chairman and excused himself from all discussion.

Dr. Armstrong reviewed three additional incident reports on Dr. Floyd Bryan since the Executive Committee met in December.

It was noted that the Executive Committee requested reports from Dr. Hunt regarding Dr. Bryan's progress. Dr. Hunt has stated that Dr. Bryan is competent, but does not feel that the

details of the counseling session would be appropriate.

Discussion followed regarding the nature of the incident reports. The committee felt the reports appeared rather vague and somewhat insignificant, but did represent a behavioral pattern. It was noted that Dr. Bryan's competence as a physician has never been in question.

A motion was made to appoint a committee to investigate Dr. Bryan's long term pattern of behavior and look into rehabilitative possibilities and make a recommendation to the Executive Committee. The motion was seconded and passed.

Dr. Gurri will appoint the committee.

MR. SCHIRTZER: Your Honor, if we may, before the court's instructions, in going through the instructions that are being given, we discovered there was no discussion on Section 395 immunities. To simplify the matters, we propose that plaintiffs' instruction number sixty one be given. The defendants are entitled to have that as a matter of law.

THE COURT: Well, I did have that. Let me see the one you have.

MS. CARROLL: I think you gave the federal one. I know you ruled and let them argue in final argument. I don't know. The only time I have said intentional fraud hasn't been defined by the legislature. It's up to you.

We do have an instruction too where you lay out the issue talking about bad faith and with malice. If that takes care of that, I don't know.

Okay. That leaves out the first part of the statute. It talks about the fair review procedures.

The Legislature hasn't defined intentional fraud, so I think that's why you probably let them just argue it in closing.

THE COURT: This is the joint.

MS. CARROLL: That's on the Health Care

2742

Quality Improvement Act.

THE COURT: All right. Well, I'll just give that after fifty eight then.

* * *

unbiased administrative hearings and a fair and meaningful appellate review process during the administrative process in which his medical staff privileges were terminated.

Due process would also require that the acts of the defendant in terminating the plaintiffs' medical staff privileges be neither unreasonable, arbitrary, capricious or malicious.

The first immunity defense is based upon a federal law known as the Health Care Quality Improvement Act which provides that a hospital will not be liable for damages if its actions were taken, one, in a reasonable belief that the action was in furtherance of quality health care; two, that after a reasonable effort to obtain the facts of the matter; three, after adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances; and four, that in a reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain such facts and after meeting the requirements of paragraph three.

Hospital by-laws when approved and adopted by the Governing Board become a binding and

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

FLOYD T. BRYAN & FLOYD T. BRYAN, M.D., P.A.,

Plaintiffs,

v. **CASE NO. 90-0896-CIV-ORL-18**

JAMES E. HOLMES REGIONAL, MEDICAL CENTER a/k/a HOLMES REGIONAL MEDICAL CENTER, INC., & OTHERS,

Defendant.

_____/

SPECIAL VERDICT FORM

I. Immunity Defenses.

A. Health Care Quality Insurance [*sic*] Act.

1. Is Holmes immune from monetary damages under the provisions of the Health Care Quality Improvement Act?

Yes___ No___

B. § 395.0115, Florida Statutes.

1. Did Holmes terminate Dr. Bryan's privileges as part of investigating and disciplining Dr. Bryan based on the reasonable belief that Dr. Bryan's conduct may have constituted grounds for discipline?

Yes___ No___

Power to control prices or to foreclose competition; and four, the overt acts manifesting such intent.

Section 395 of the Florida Statutes require that hospitals handle staff privilege in conformity with basic fairness and due process. The statute specifically states each licensed facility as a condition of licensure shall provide for peer review of physicians who deliver health care services at the facility. Each facility shall develop written binding procedures by which such peer review shall be conducted. Such procedures shall include, A, a mechanism for choosing the membership of the body or bodies that conduct the paper [*sic*] review, B, the adoption of rules of order for the peer review process, C, fair review of the case with the physician involved, and D, a mechanism to identify and avoid conflict of interest on the part of the peer review panel members.

Section 395 of the Florida Statutes also provides that there shall be no monetary liability or cause of action for damages against participants in the peer review process for any action taken in good faith and without intentional fraud in carrying out the provisions of the statute.

A person in the plaintiff's position may not have his staff privileges terminated unless procedures

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 92-2963

FLOYD T. BRYAN &
FLOYD T. BRYAN, M.D., P.A.,

Plaintiffs/Appellees/Cross-Appellants

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,

Defendant/Appellant/Cross-Appellee

On Appeal from the United States District Court
For the Middle District of Florida

BRIEF OF AMICI CURIAE THE AMERICAN MEDICAL ASSOCIATION AND THE FLORIDA MEDICAL ASSOCIATION

OF COUNSEL

Kirk B. Johnson
Edward B. Hirshfeld
Michael L. Ile
AMERICAN MEDICAL
ASSOCIATION

Jack R. Bierig
Richard D. Raskin
Susan A. Weber
SIDLEY & AUSTIN
One First National Plaza

515 North State Street
Chicago, Illinois 60610
(312) 464-5000

Chicago, Illinois 60603
(312) 853-7000

John E. Thrasher
FLORIDA MEDICAL
ASSOCIATION
760 Riverside Avenue
Jacksonville, Florida 32203
(904) 356-1571

ATTORNEYS FOR
AMICI CURIAE
THE AMERICAN MEDICAL ASSOCIATION
AND THE FLORIDA
MEDICAL
ASSOCIATION

June 17, 1993

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 92-2963

FLOYD T. BRYAN &
FLOYD T. BRYAN, M.D., P.A.,

Plaintiffs/Appellees/Cross-Appellants

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,

Defendant/Appellant/Cross-Appellee

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Eleventh Circuit Rules 26.1 and 28.2(b), counsel for amici curiae the American Medical Association and the Florida Medical Association certify the following list of persons or entities that have an interest in the outcome of this case:

1. American Hospital Association
2. American Medical Association
3. Raymond A. Armstrong, M.D.
4. Richard N. Baney, M.D.
5. William A. Bell, Esq.
6. Jack R. Bierig, Esq.
7. Floyd T. Bryan, M.D.
8. Floyd T. Bryan, M.D., P.A.
9. Mrs. Floyd T. Bryan
10. Carlton, Fields, Ward, Emmanuel, Smith & Cutler, P.A.
11. Jennifer S. Carroll, Esq.
12. The Honorable Donald Paul Dietrich
13. Frederic J. Entin, Esq.
14. Florida Hospital Association
15. Florida Medical Association
16. Michael J. Foley, M.D.
17. Foley & Lardner
18. Michael V. Gatto
19. Mrs. James E. Gray, III
20. Edward B. Hirshfeld, Esq.
21. James E. Holmes Regional Medical Center, a/k/a Holmes Regional Medical Center, Inc.
22. Michael L. Ile, Esq.
23. Martin W. Isenman, M.D.
24. Kirk B. Johnson, Esq.

25. Maj. Gen. David M. Jones
26. Christopher K. Kay, Esq.
27. Jane Kreusler-Walsh, Esq.
28. Leland Lovering, Esq.
29. Michael F. Maguire
30. Fred L. McFarlin
31. Metzger, Sonneborn & Rutter, P.A.
32. John E. Miller, Ph.D.
33. Barry A. Mills, M.D.
34. George H. Moss, Esq.
35. Moss, Henderson, Van Gaasbeck, Blanton & Koval, P.A.
36. Richard D. Raskin, Esq.
37. Ila Rothschild, Esq.
38. Lyle Saltzman, M.D.
39. Ronald M. Schirtzer, Esq.
40. The Honorable G. Kendall Sharp
41. Sidley & Austin
42. Val M. Steele
43. Lynn Stoldt, R.N.
44. Russell P. Sullivan, Jr.
45. Alan C. Sundberg, Esq.
46. John E. Thrasher, Esq.
47. William Trickle, Jr., Esq.
48. John F. Turner, Jr.
49. Sylvia H. Walbolt, Esq.
50. Susan A. Weber, Esq.
51. Rita Wheeler, R.N.

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42 U.S.C. § 11101 . . . . . 2, 3, 4, 5

42 U.S.C. § 11111(a) 5, 6

42 U.S.C. § 11112(a) 6, 7, 10

42 U.S.C. § 11112(b) 8

42 U.S.C. § 11133 5

LEGISLATIVE HISTORY

*H.R. Rep. 903, 99th Cong., 2d Sess. 2, reprinted in 1986 U.S.C.C.A.N. 6384 . . . . . 5, 6, 7, 8, 10

132 Cong. Rec. 30767 (Oct. 14, 1986) 6, 7

*Indicates authorities upon which amici principally rely.

BRIEF OF AMICI CURIAE AMERICAN MEDICAL ASSOCIATION AND FLORIDA MEDICAL ASSOCIATION

The American Medical Association and the Florida Medical Association respectfully submit this brief as amici curiae in support of appellee Floyd Bryan, M.D. This brief is filed with the consent of both parties, pursuant to Rule 29 of the Federal Rules of Appellate Procedure. Copies of the letters establishing the parties' consent are appended to this brief.

INTEREST OF AMICI CURIAE

The American Medical Association ("AMA") and the Florida Medical Association ("FMA") are private, voluntary, nonprofit organizations of physicians. Both associations are dedicated to promoting the science and art of medicine and the improvement of public health. The membership of the AMA exceeds 280,000 physicians, including thousands who practice medicine in states within the Eleventh Circuit. The membership of the FMA consists of approximately 17,000 Florida-licensed physicians, making FHA the largest physician organization in the State of Florida.

The AMA and FMA are dedicated to promoting the public welfare through the maintenance of high professional standards and the provision of quality health care. In pursuit of these goals, the AMA, the FMA, and their members participate in a wide range of peer review programs. Peer review is the process through which the medical profession assesses the competence and conduct of its members. Hospital medical staffs, medical societies, and other physician groups utilize peer review to help assure that physicians provide quality medical care for patients and adhere to appropriate professional standards.

This appeal presents the Court with its first opportunity to address the protections for the peer review process created by the Health Care Quality Improvement Act of 1986, ("HCQIA"), 42 U.S.C. § 11101 et seq. It arises on a record in which a jury found that the defendant Holmes Regional

Medical Center, through its actions, forfeited the immunity conferred by the Act. The record includes facts which support the jury's verdict. The interest of amici is to urge the Court, in affirming the judgment below, to limit its decision to those unique facts but at the same time to make clear that the HCQIA requires a grant of summary judgment to all who engage in fair and reasonable peer review of physicians.

STATEMENT REGARDING ADOPTION OF BRIEFS OF OTHER PARTIES

Pursuant to Rule 28(i) of the Federal Rules of Appellate Procedure and Eleventh Circuit Rule 28-2(3), the AMA and the FMA adopt the following portions of the brief of Plaintiff/ Appellee/Cross-Appellant Floyd T. Bryan:

- Statement of Jurisdiction
- Statement of the Case and Facts
- Standard of Review

STATEMENT OF ISSUES

The AMA and FMA, as amici curiae, will address the following issue:

- Whether the protections for the peer review process embodied in the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., shield the Holmes Regional Medical Center from liability for damages from its termination of the staff privileges of Floyd Bryan, M.D.?

SUMMARY OF ARGUMENT

Congress enacted the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11101 et seq., to encourage peer review by immunizing participants from most actions for damages by disciplined physicians. Moreover, Congress directed that those who engage in fair peer review not be exposed to protracted litigation that would -- regardless of outcome -- discourage participation in the peer review process. For these reasons, in the vast majority of damage actions based on peer review proceedings, courts should grant summary judgment to defendants.

In this case, a jury concluded that the Holmes Regional Medical Center did not afford Dr. Bryan basic fairness in revoking his staff privileges. After reviewing the record, this Court should conclude that the actions of the Medical Center were so fundamentally unfair that the presumption of immunity under the Health Care Quality Improvement Act has been rebutted and that the judgment of the District Court should therefore be affirmed. However, in affirming that judgment, the Court should make clear that its decision is based on the unique and extraordinary facts of this case and that there is no reason for physicians and hospitals that have conducted peer review in good faith to be concerned about imposition of damages or even involvement in plenary trial proceedings.

I. THE HEALTH CARE QUALITY IMPROVEMENT ACT PROVIDES IMMUNITY FROM DAMAGES FOR PARTICIPANTS IN FAIR AND REASONABLE PEER REVIEW

"The purpose of [the Health Care Quality Improvement Act] is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.

Rep. 903, 99th Cong., 2d Sess. 2, reprinted in 1986 U.S.C.C.A.N. 6384, 6384. To accomplish this goal, HCQIA:

> 1) provides immunity from liability for damages for physicians and organizations that participate in the peer review process, 42 U.S.C. § 11111(a); and
> 2) mandates that the results of peer review proceedings be reported to a national clearinghouse, id. § 11133.

Only the peer review provisions of the statute are at issue here.

Prior to the passage of the HCQIA, the threat of litigation seriously impeded the peer review process. Indeed, Congress expressly found that "[t]he threat of private money damage liability . . . discourage[d] physicians from participating in effective professional peer review." Id. § 11101(4). Congress therefore found an "overriding national need to provide incentives and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(5).

The HCQIA addresses that "overriding national need." It immunizes participants in the peer review process from liability for damages in most private actions if the peer review proceedings meet certain minimum standards. 42 U.S.C. § 11111(a). See Goldsmith v. Harding Hospital, Inc., 762 F. Supp. 187, 188 (S.D. Ohio 1991).[1] The HCQIA creates a presumption that the peer review proceeding conformed to those standards:

> A professional review action shall be presumed

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[1] The immunity provision does not apply to claims based on violations of federal or state civil rights laws. 42 U.S.C. § 11111(a)(1). Moreover, it does not bar any action brought by the United States or any State. Id.

> to have met the . . . standards necessary for the protection set out [above] unless the presumption is rebutted by a preponderance of the evidence.

42 U.S.C. § 11112(a). Thus, "the burden of proof . . . rests on the plaintiff, not the defendant" peer reviewers, to show that a peer review proceeding failed to conform to the standards of the HCQIA. 132 Cong. Rec. 30767 (Oct. 14, 1986) (statement of Rep. Waxman) (floor leader). See also Smith v. Ricks, 798 F. Supp. 605, 611-12 (N.D. Cal. 1992).[2]

The standards of the HCQIA are designed to promote reasonableness and procedural fairness. They require that a professional review action be taken --

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,

---

[2] In the original draft of the bill, the presumption applied to only one of the four standards that a peer review action must meet to benefit from the HCQIA immunity provisions. Plaintiffs were required to produce clear and convincing evidence to rebut that presumption. See H.R. Rep. 903, 99th Cong., 2d Sess. 10, reprinted in 1986 U.S.C.C.A.N. at 6393. The bill was subsequently amended to apply the presumption to all four standards. Plaintiff's burden was reduced from a clear and convincing showing to a simple preponderance. See 132 Cong. Rec. 30767 (Oct. 14, 1986) (statement of Rep. Waxman).

> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).

Id. § 11112(a). See Patrick v. Burget, 486 U.S. 94, 105-06 n.8 (1988).

In virtually all peer review litigation, the presumption that peer reviewers acted reasonably and fairly should result in early dismissal of the lawsuit. Congress "intend[ed] that [the HCQIA] allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible." H.R. Rep. 903, 99th Cong., 2d Sess. 12, reprinted in 1986 U.S.C.C.A.N. at 6394. Accord 132 Cong. Rec. 30767 (statement of Rep. Waxman) . See also Fobbs v. Holy Cross Health System Corp., 789 F. Supp. 1054, 1066 (E.D. Cal. 1992) ("[t]he question of immunity is a matter of law"). E.g., Austin v. McNamara, 979 F. 2d 728 (9th Cir. 1992); Smith v. Ricks, 798 F. Supp. at 611-12.[3]

For example, a plaintiff may not survive a motion to dismiss simply by alleging that procedural irregularities occurred in the peer review process. Although the HCQIA

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[3] See generally Mahmoodian v. United Hospital Center, Inc., 404 S.E.2d 750, 756 (W. Va.), cert. denied, 112 S. Ct. 146 (1991) ("it is evident that the intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise").

sets forth procedural guidelines, see 42 U.S.C. § 11112(b), the statute expressly states that the failure of a review body to meet these guidelines does not violate the statute's procedural fairness standard. Id.[4] Similarly, HCQIA immunity may not be abrogated by a plaintiff's general assertion of hostility on the part of peer reviewers. See Austin v. McNamara, 979 F.2d at 734. Such allegations "are irrelevant to the reasonableness standards of the [statute]. The test is an objective one, so bad faith is immaterial." Id.[5]

Thus, in virtually all cases, physicians who have been disciplined by peer review proceedings will be unable to carry their burden of establishing that the proceedings were unreasonable or procedurally unfair. In most instances, plaintiffs' claims for damages should therefore be dismissed before trial.

II. THIS IS THE RARE CASE IN WHICH THE PLAINTIFF ADDUCED SUFFICIENT EVIDENCE TO REBUT THE STATUTORY PRESUMPTION OF IMMUNITY

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[4] Because "[t]he failure to meet the [procedural] standards [of the HCQIA] . . . creates no presumption with respect to the liability or lack of liability of a health care entity," Congress opined that [s]uch failure would, therefore, be inadmissible in evidence in any litigation between a physician and any person or group engaged in peer review. The only conclusion that follows from a failure to meet those standards is that the entity is not entitled to the immunity conferred under this legislation." H.R. Rep. 903, 99th Cong., 2d Sess. 11, reprinted in 1986 U.S.C.C.A.N. at 6393-94.

[5] Indeed, Congress considered and rejected a "good faith" standard for peer review proceedings so that the immunity test could not be interpreted as requiring an inquiry into the "subjective state of mind of the physicians conducting the professional review action." See H.R. Rep. 903, 99th Cong., 2d Sess. 10, reprinted in 1986 U.S.C.C.A.N. at 6392-93.

The HCQIA does not, however, bestow absolute immunity upon peer review proceedings. A plaintiff who has rebutted the presumption that a professional review action was conducted reasonably and fairly is entitled to proceed to trial. As discussed below, this is the rare case in which a plaintiff has made the requisite showing.

In particular, Dr. Bryan has adduced evidence of one critical fact: The Board of Holmes Regional Medical Center terminated his staff privileges without regard to the most pertinent parts of the record in his case. The Board ignored the work of two separate peer review panels that had heard testimony and examined the evidence against Dr. Bryan. See Brief of Plaintiffs/Appellees/Cross-Appellants at 10-12, 19-20. Instead, the Board acted on the basis of incident reports that had been found to be unreliable by the first panel. Id. The Board did not even consider the record of the hearings conducted by the second panel. Id. at 19-20. That panel had recommended a two-year suspension of Dr. Bryan's staff privileges -- not the permanent termination of privileges imposed by the Board.

Consideration of the evidentiary record is vital to the reasonable and fair disposition of a peer review proceeding. Thus, the Board's action raises questions under two of the four requirements for immunity under the HCQIA. First, the jury could have found that the Board did not act "after a reasonable effort to obtain the facts of the matter," 42 U.S.C. § 11112 (a)(2), because it disciplined Dr. Bryan without regard for the factual record in his case. Second, because the Board ignored the record, the jury could have found that the Board did not act "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts." § 11112 (a)(4). In these circumstances, this Court should affirm the judgment of the District Court.

At the same time, however, the Court should make clear that this case is highly atypical. The vast majority of

peer review proceedings are both fair and reasonable. See H.R. Rep. 903, 99th Cong., 2d Sess. 10, reprinted in 1986 U.S.C.C.A.N. at 6392-93 (stating that the HCQIA immunity standards will "be met in the overwhelming majority of professional review actions"). The physicians and institutions that participate in these proceedings should be assured that they will not be subjected to prolonged litigation, let alone liability for damages. The Court should not allow the anomalous facts of this case to color its interpretation of the HCQIA and thereby undermine the peer review process generally.

Under the HCQIA, the vast majority of lawsuits challenging peer review proceedings should be dismissed at the summary judgment stage. Suits against peer reviewers should be allowed to go forward only when the plaintiff has rebutted the presumption that the peer review proceeding was reasonable and fair. Any lesser standard would deter physicians from serving as peer reviewers and would thereby undermine the purpose of the HCQIA.

CONCLUSION

In sum, the judgment of the District Court should be affirmed. In deciding this case, however, the Court should take care not to undermine the protections that the HCQIA provides to the vast majority of peer review proceedings.

Respectfully submitted,

/s/ Jack R. Bierig

Kirk B. Johnson
Edward B. Hirshfeld
Michael L. Ile
AMERICAN MEDICAL

Jack R. Bierig
Richard D. Raskin
Susan A. Weber
SIDLEY & AUSTIN

ASSOCIATION
515 North State Street
Chicago, Illinois 60610
(312) 464-5000

One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

John E. Thrasher
FLORIDA MEDICAL
ASSOCIATION
760 Riverside Avenue
Jacksonville, Florida 32203
(904) 356-1571

ATTORNEYS FOR
AMICI CURIAE
THE AMERICAN MED-
ICAL ASSOCIATION
AND THE FLORIDA
MEDICAL ASSOCIA-
TION

CERTIFICATE OF FILING

I, Jack R. Bierig, an attorney in this matter, hereby certify that I caused copies of the attached brief of amici curiae the American Medical Association and the Florida Medical Association to be filed by Federal Express this 17th day of June, 1993.

/s/ Jack R. Bierig

CERTIFICATE OF SERVICE

I, Jack R. Bierig, an attorney in this matter, hereby certify that I caused copies of the attached brief of amici curiae the American Medical Association and the Florida Medical Association to be served by Federal Express upon the following:

Sylvia H. Walbolt, Esq.
Carlton, Fields, Ward, Emmanuel, Smith & Cutler, P.A.
One Harbour Place
Tampa, Florida 33601

Christopher K. Kay, Esq.
Foley & Lardner
111 North Orange Avenue, Suite 1800
Orlando, Florida 32802-2193

Jennifer S. Carroll, Esq.
Metzger Sonneborn & Rutter
1615 Forum Place, Suite 300
West Palm Beach, Florida 33402-4486

William Bell, Esq.
Florida Hospital Association
120 South Monroe Street
Tallahassee, Florida 32301

Frederic J. Entin, Esq.
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

this 17th day of June, 1993.

/s/ Jack R. Bierig

his reputation?

A. Yes.

Q. Would you tell the panel about that?

A. I can't remember exactly when I started hearing certain things about Dr. Bryan, but whenever there was some -- or many times when someone was disgruntled in the operating room, his name was mentioned as being the person who started some sort of a furor or made the other person disgruntled.

Q. Were you aware of any enemies that Dr. Bryan had on the medical staff?

A. Well, I think he did have some enemies, yes,

Q. Among who, people in power?

A. I think so.

Q. Chiefs of Staff?

A. No.

Q. Who could you say or would you say?

A. Why don't you name somebody.

Q. Dr. Gurri.

A. Yes.

* * *

in the suspension of privileges of Dr. Bryan?

A. Well, I think that's a tremendous simplification of this entire matter. I don't think we could possibly put it quite like that, I would say that if I had to make a summary of it I would say that the incident reports reflect a pattern of behavior that progressively and gradually, being dealt with by the Executive Committee at multiple meetings with Dr. Bryan upon his review of the matter, multiple counselings and so forth, eventually ended up in the suspension. I don't think one can simply say twenty three incident reports, then suspension. It's a complex matter.

Q. All right. And we'll get into it. Dr. Gurri, as of November 30, 1988, were you doing vascular and general surgery?

A. In 1998 I was.

Q. Were you a competitor of my client, Dr. Floyd Bryan, as of that date, sir?

A. I did not consider myself much of a competitor, but I certainly did do what he did. We had what I felt was very different referral circles and my referral pattern really has not changed much in the point since 1986. He had his circles, I had mine, but I was doing vascular surgery at that time.

Q. And did this Committee, just referring to this document which is Plaintiff's 208, and it's already in evidence, so I won't offer it, but it's the Executive Committee Meeting of February 19, 1988. Where we found later on that Dr. Gurri had appointed these three people to monitor your, quote, behavior, right, and implement the plan reflected in the letter that we talked about of March 17 of 1988; is that right?

A. Yes, sir.

Q. Do you know why they picked two men that you had, why Dr. Gurri picked two people that you had strong disagreements with?

MR. KAY: Objection, calls for speculation.

THE COURT: Sustained.

Q. Let me ask you this, doctor. What was your relationship with Dr. Gurri?

A. The mildest thing I can say is we didn't speak. I think the truth of the matter is the same thing that Dr. Unger told me about 19 --

Q. He'll be up, don't tell them what other people said.

A. Okay. Even if they told it to me?

Q. Well, if they told it to you, you can say it, but don't repeat what other people said.

A. No, Dr. Unger told me, he said Floyd, I want you to know --

MR. KAY: Your Honor, I'm going to object to this because I believe it is offered for the truth of the matter asserted.

THE COURT: Sustained.

Q. What was your relationship with Dr. Gurri?

A. He really hated my guts.

Q. Okay. Do you know why?

MR. KAY: Objection, calls for speculation.

THE COURT: Overruled.

A. Yeah, I think I hurt his ego and I think possibly I hurt his ambitions to be a vascular surgeon.

Q. And this man, did you feel the same way toward him? You said you didn't speak.

A. Well, he had done several things I thought were kind of sleazy or underhanded or not good pool or whatever. Dirty pool. And so I just try to avoid him. I was actually, if I had a choice of having Dr. Gurri practice in town and me be in town again by myself, I would rather have Dr. Gurri because he took some of the load off. I mean, I just could not do it all.

Q. Now, likewise same question with Dr. Armstrong, what type of surgeon is he?

A. He's a general surgeon.

Q. And what does a general surgeon do as it is presently used? The types of operations.
A. Well, hernias, in lay terms, gallbladders, colon operations, large bowel operations, thyroid operations, breast operations.

Q. And do you do that also?
A. I did as a general surgeon, yes.

Q. While you were practicing, did you do general surgery?
A. Yes.

Q. And likewise with Dr. Gurri, what type of surgeon is he?
A. He's a general surgeon and a vascular surgeon.

Q. And you have heard him testify he now doesn't want to do any more vascular surgery?
A. Right. He's graduated towards general surgery.

Q. Now, the other physician whose name has been mentioned is Dr. Shamma.
A. Yes, sir.

Q. Did you approach Dr. Shamma about working with you?
A. Yes, sir.

basketball player.

(Witness excused)

THE COURT: Call your next witness.
MR. MOSS: I would call Dr. Armstrong, Jr., M.D.

THEREUPON,
RAYMOND ALTON ARMSTRONG, JR., M.D.

Having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MOSS:

Q. Good morning, doctor.
A. Good morning.

Q. Would you tell the jury your full name, please.
A. Raymond Alton Armstrong, Junior.

Q. What is your present occupation, doctor?
A. I'm a surgeon.

Q. And do you limit your practice within the field of surgery?
A. Yes, general surgery,

Q. Prior to limiting your practice back in 1990, 1991, did you advertise yourself as a vascular surgeon?
A. I beg your pardon? Would you repeat that?

Q. In 1990 and 1991, did you advertise yourself as a general and vascular surgeon?
A. No.

Q. When did you last advertise yourself as being a vascular surgeon?

A. I never advertised myself as a vascular surgeon.

Q. Did you ever in the yellow pages of the phone book have an ad that said general and vascular surgery?

A. I don't recall that I did. I did do some vascular surgery when I first came to Holmes Medical Center in 1975. I don't recall that I ever advertised that in the yellow pages.

Q. So during the entire time that you have been at Holmes, you have been a general surgeon?

A. I did vascular surgery for a very brief period of time.

Q. All right, sir. Did Dr. Floyd Bryan also do vascular surgery?

A. Dr. Bryan did vascular surgery.

Q. And does he also do general surgery?

A. Yes.

Q. Did he up until his suspension?

A. Yes.

Q. At one point, did you and Dr. Bryan work in the same group?

A. Yes.

Q. When was that?

arrived in the Department of Surgery I gave Dr. Bryan myself.

Q. You gave him yourself?
A. Yes.

Q. No return receipt requested, just you one on one with your old former working mate?

A. Well, that's where the process could stand some improvement. We needed to document the facts and indeed, we made every attempt to improve the method. We tried to be very fair and improve the process, yes, sir.

Q. Gave every benefit of the doubt to the doctor?

A. I feel we did, yes, sir.

Q. And you despise or dislike Dr. Bryan, don't you?
A. Well, which word would you choose?

Q. Which one would you choose, sir?
A. I did say in testimony one time --

Q. Under oath.
A. Under oath, that I didn't particularly like Dr. Bryan.

Q. Is that true?
A. Yes.

Q. Has that been true for some period of time?
A. Often, yes, there are times when I have been very friendly with Dr. Bryan.

This is for the benefit of the jury; is exhibit 67 the incident report that was prepared upon your return from being out of town and discovering that a particular patient on who you had operated no longer had his foot extended and elevated?

A. Yes, sir.

Q. This is the chiropractor we talked about?

A. Yes, sir.

Q. And did you state to the family, quote, I am sorry he was mistreated here. I should have stayed here. We had his left leg nearly straight and now he is contracted. Where is the spandex? It is too late for you nurses to watch him now. I operate 14 hours and then lose the foot. Did you make that statement to the family?

A. I made some of it, yes, sir. I remember apologizing, I was sorry that, that -- I was sorry that this had happened, that somewhere between the intensive care unit where I had left him on auto pilot, and the floor, that the ball had been dropped. I remember stating, well, maybe I should have stayed here, I really felt badly about it. I remember having his leg almost straight and now he's contracted it back up. And I don't, I don't think I said I was sorry that he was mistreated here. And I don't think

I said to the family it's too late for you nurses to watch him now. I may have said that to them later somewhere else. But no, I don't think I said that then.

Q. And did you also indicate in your chart that you apologized to the family on behalf of the hospital?

A. I think I wrote, yes, for the hospital.

Q. For the hospital. And that's because when you returned from being on vacation or being out of town, you naturally assumed that the nurses were the ones that had not followed your orders; isn't that right?

A. No, sir. This was actually, what I actually did, as I said sometime, maybe yesterday, I had operated on this patient, we had him on, when I signed out, he's on auto pilot, everything is written, he's in the ICU, I thought he would still be in the ICU. And if he clotted, that was all that could be done, just lose his leg if the graft clotted.

And I came back, went to the ICU, he wasn't there. And they said he was up on the floor, so I went up on the floor and I saw him bent all up, sitting on his foot again. And I immediately went and got the chart and went through the chart. And I went through the orders backwards, several orders that I went through and the only one I saw was the doctor

A. Yes, sir, there were discussions to that effect.

Q. And who were those people that were encouraging people to write you up?

A. Only two or three were directly named.

MR. KAY: Your Honor, again, may I insert an objection here? I believe that your question was in some sense a compound one. If your --

THE COURT: All right, only if any of the defendants spoke to you, sustain what they said.

Q. Did any of the defendants speak to you directly, sir?

A. Oh, no, sir, they wouldn't.

Q. All right. Let's move along then. Yesterday, doctor, when we were talking about your qualifications, I neglected to have marked for identification your CV, which is our number 116-A. We would offer that at this time, Your Honor.

Now, after this ad hoc committee that you testified never talked to you, nothing happened, there was an incident which occurred with the two anesthesiologists around May of 1987; is that correct? '88 I'm sorry.

A. Yes, sir.

Q. Would you tell the jury, sir, the events that led up to your getting angry at two anesthesiologists

in May of 1988?

A. Yes, sir. One of them was a, the first one, Dr. Saucedo, I had a critically ill young man, 38, 40 or so, with chronic pancreatitis who had acute pancreatitis. I have to explain that a little bit. The pancreas has digestive enzymes in it. And when you get pancreatitis, it swells, the same thing as in mumps. It swells and these enzymes can leak out, not down the ducts into the intestines, but leak out into the body, into the body cavity. And you can literally digest yourself away.

Q. Do what?

A. You can digest yourself from the inside.

Q. How does that happen?

A. Because these digestive enzymes leak out of the pancreas. Leak out the sides, rather than going into the intestine. Anyway, and it can, it can, you know, eat away at blood vessels sort of like a beaver going around a tree I suppose, you know. And then they blow out. And this man was critically ill. He was not in shock at that moment, but he had been shocky and we determined that we were afraid that he was bleeding internally, his blood level was dropping and all that sort of thing. And after, oh, I don't know, he had been posted the day before.

Q. Posted is what?

A. I had mentioned it the day before to be on the operating schedule. You know, if he doesn't get better, we're going to have to operate on him, so you put him on the operating schedule. You can always cancel; it's hard to get on, easy to get off. And so sort of put him on. And I came down the hall getting ready to do him, I heard they called for him, so I went, and in the room there was Dr. Saucedo and two or three other anesthesiologists and they were resuscitating him.

Q. What does that mean?

A. I mean he had arrested, he had vomited and sucked all this stuff into his lungs and he had arrested. And it worked out, usually when somebody's in the intensive care unit and they are sick, the anesthesiologist goes and goes with them to the operating room, in case something happens. And in this case, he had simply just, number one, I don't think any anesthesiologist had ever seen the patient. And they usually do. Nobody had seen the patient, of course, he skipped the holding room because he is too sick, goes directly from the intensive care unit to the operating room itself. And Dr. Saucedo had sent for the patient and when he got there, however long it

took, three minutes or so, patient vomited and aspirated and almost died.

We had to ship him back to the intensive care unit to get him over that, and he kept getting sicker and sicker, and I finally took him back to the operating room and then we did put him under anesthesia and explored, we couldn't find anything that we could fix, and he died.

Q. Did that upset you?

A. Well, two things upset me. He died upset me the most. But the, it really upset me that the anesthesiologist would take a man this desperately ill, maybe he would have died anyway, probably would have, but take a man this desperately ill and send a nurse to go get him. That really bothered me.

Q. That was when in relation to the incident where you got him mad?

A. Oh, a week.

Q. So for a week, you kind of, did you do anything about that first one?

A. No, sir, I didn't know Dr. Saucedo very well, I didn't want to say anything because it was my first encounter with him, and.

Q. Ad hoc committee come into mind?

A. By then I was, you know.

good surgeon and I did good work, and then Mr. Wilford said these incident reports are insignificant, but, I think he used the word insignificant and sheer volume. Those are the two words I remember. And then we talked for awhile and I said, do you want to go over each one? And they said no, it's just sheer volume, there is no need to go over any one. And then Dr. Stall said --

MR. KAY: Objection, Your Honor, that calls for hearsay.

THE COURT: Sustained.

A. Well, that was a suggestion.

Q. Did anyone recommend to you, sir, how to criticize without a direct confrontation?

A. Yes, sir.

Q. And what recommendation was given to you?

A. Dr. Stall recommended that I write letters.

Q. And letters about what?

A. Any kind of dissatisfaction, if I had made anybody angry or if they made me angry or had upset me or just anything. Just write a letter.

Q. And over the years, did you have, or after that period of time, and before, had you had problems with anesthesia?

A. Oh, yes, sir. That was kind of a chronic

problem. It got worse.

Q. It got worse, when?

A. '87, '88.

Q. What problems were you having with anesthesia?

A. I didn't have problems with the individual anesthesiologist; I think everybody's good at some things and better at others. But, and they were all different. As far as the individual anesthesiologists were concerned, the major problems I had was the way they sort of ran their business, if you will. Ostensibly it was a very complex system of checks and balances, which I'm sure on paper looks terrific, but in practice it didn't work. Because the anesthesiologists from what I saw would have somebody see the patient the night before their operation. Unless they came in as an outpatient. Then they would have somebody else see them in the holding room and they'd have a third person see them in the operating room.

That's terrific, you have got three doctors reviewing the chart. The only problem is they didn't talk to each other. I mean, I would talk, sometimes I would catch the first anesthesiologist on the ward and say Mrs. So-and-So has this problem, that problem, we really want to watch out for this or that because I

had interviewed her, I examined her, I knew her, she is my patient. And by the time it got to the third anesthesiologist, he didn't know anything about it. He'd never heard anything about that, you know. And so you didn't know where that was coming at.

The second thing, problem I had is that they would change off a lot between cases, and I can understand on a 12, 14 hour case, can't, you can't have the same doctor all the time, even though you'd like to. But.

Q. Why couldn't you?

A. Well, they work their hours.

Q. Did you change off in the middle of the surgery?

A. No, sir, that wasn't part of the contract, or whatever. But anyway, I really, I thought that, I mean they had to take breaks and things and everybody understands that. I felt very strongly because I think the person who put the patient to sleep ought to be the person to wake them up. Because those drugs are dangerous. And I don't think anybody will ever deny that.

Q. Did you write letters to them about problems that you had?

A. Yes, sir. I had other problems later on, it got so, if I had a case scheduled for 7:30, it routinely

wouldn't start until 8:30. They always had something to do and they were reviewing the chart and they couldn't get this in and they couldn't do that, you know, just sort of dragging your feet.

Q. And so you did write letters about that?

A. Yes, sir.

Q. And did you have problems with the people in the emergency room?

A. Only a couple of problems, yes.

Q. And who was Chief of the emergency room at the time?

A. Dr. Gettings.

Q. And Dr. Scott Gettings?
A. Yes, sir.

Q. What problem did you have or problems with the emergency room?

A. The first one I can remember was the Palm Bay shootout, some guy went berserk with a rifle and in a shopping center, supermarket. And they had all these injured people coming and I think I was the surgeon on call. But anyway, there were a lot of surgeons down there, was during the day. And I picked a lady who looked pretty sick, first pretty sick lady that came in and I said okay, I'll take her. And we did this at the door, as they're coming into the emergency

Not as important. If you're asking how we use this information?

Q. Yes.

A. The way we use this information is principally for resource allocation. You'll see the people at the bottom of this list, two of them at least, are heart surgeons, and you know, our heart program is a very important program to provide to the community. And so as we sit down each year in the budgeting process we determine how much, how many people, how many dollars, what kind of equipment is going to have to go into these various programs. It's important for us to know, in essence, how much we're going to be reimbursed for those services. And sixty percent of our patients are Medicare patients now and so that Medicare program is being cut back on a regular basis. And so for planning purposes it's important internally that we know where to put these resources, where the needs are going to be.

Q. You're not aware, are you, sir, that the American College of Surgeons requires that a surgeon discharge a surgery patient?

A. No, sir, I'm not aware of that.

Q. And if this is misleading then, it's misleading for all of the doctors because if Dr. Armstrong was

you used that for your criteria, you'd end up possibly with at least twenty five or thirty percent of the entire staff, maybe more than that.

Q. Is it of any interest to you as Administrator of the Trustees as the owners of the Hospital as to whether a doctor contributes to the bottom line?

A. No, sir, it's not. We are a Community Hospital, as I said, and as a result we take every patient who comes to the door. We run an Emergency Department twenty four hours a day. We're now going to have two of them, we're going to have one in Palm Bay too, and in essence we treat the people who come to our doorstep. And regardless of who treats them or how they're treated, we do not turn people away. That's part of our mission, that's part of our history and our heritage and we have not ever done that.

Q. Okay, sir. And do you also have an analysis in that same document in front of you as to the profitability or non-profitability for Medicare versus Non-medicare patients? Let me direct your attention to page thirty two.

A. Is this the first thirty two?

Q. I don't know how many thirty twos. Mine is, it's page thirty two. It says Holmes Regional Financial Analysis by specialty physician and payer or

patients for this snapshot, Dr. Armstrong's profit per case, what does that mean, the --

A. Well, that's essentially the difference between the revenues and the expenses after you factor out bad debt, charity, contractual discounts, which is what happens under Medicare.

Q. And we'll just talk about Medicare for Dr. Armstrong was eight hundred and ninety one dollars for this period of time.

A. Yes, sir.

Q. Now, flip the page over on page thirty three, if you'll read it right off?

A. I don't have it. Excuse me. I only had thirty two.

Q. Sorry to flip over the page if you don't have it? [*sic*]

A. This is the same.

Q. That's the same information for a different doctor. Let's take, for example, Dr. Gurri.

A. Yes, sir.

Q. And his profit per case is how much for Medicare patients during October to April '90?

A. Two sixty eight.

Q. All right. And down at the bottom we have physician 1033, Dr. Bryan, and you'll have to go back

and get the next one. I'm sorry. And under Dr. Bryan, this is from the period of October of '89 through April of 1990?

A. Right.

Q. And this is right coincidentally the period of time that he was still allowed to work right before he was suspended, right?

A. Yes, sir.

Q. Okay. And at that period of time, under Dr. Bryan, how much profit was he making per case, according to your figures?

A. On the Medicare patients?

Q. Yes, sir.
A. Was minus eleven hundred dollars.

Q. So the other guys were making you money and Dr. Bryan was losing you money?
A. No, sir.

Q. Why was that? Don't they pay the same for all doctors?

A. No, sir. that's a complete mischaracterization of the evidence and the data. What that means is that most likely, and I'd be guessing, but first of all --

Q. I don't think, Your Honor, that I should want him to guess. If you know, please tell the jury. Don't guess.

HOLMES REGIONAL MEDICAL CENTER, INC.
FINANCIAL ANALYSIS BY SPECIALTY,
PHYSICIAN, AND PAYOR GROUP
INPATIENT - OCTOBER 1989 - APRIL 1990
25 JULY 1990

SPECIALTY SUR	CASES	PROFIT	PROFIT/CASE
ARMSTRONG			
MEDICARE	42	$ 37,407	$ 891
NON-MEDICARE	61	$126,646	$2,076
TOTAL	103	$164,053	$1,593
* * *			
GURRI			
MEDICARE	70	$ 18,781	$ 286
NON-MEDICARE	77	$120,110	$1,560
TOTAL	147	$138,891	$ 945
* * *			
BRYAN			
MEDICARE	59	($ 65,405)	($1,109)
NON-MEDICARE	53	$109,648	$2,069
TOTAL	112	$ 44,243	$ 395
* * *			

the question who's working with him today?

A. It was maybe not the question itself; it was the way in which it was said.

Q. I see. And what is disparaging about the question what does he plan on doing today when asking about the kind of surgery that's to be performed?

A. Well, Dr. Bryan was a forerunner in the vascular surgery at Holmes, and he was very innovative with his techniques, and there were a few surgeons who took issue with this.

Q. You indicate -- Do you believe that they're taking issue with this by the fact they're asking what kind of surgery is he going to do today?

A. Yes, yes. Do you understand what I'm saying?

Q. No, ma'am.

A. Okay. Dr. Bryan was one of the first surgeons that did a composite graft. Now, that was part man-made material and part body material. And at that time this was considered very innovative, and it was also an extreme measure, and there were some surgeons who felt that this was not to the benefit of the patient.

Q. Did they tell -- Did those physicians tell you that?

A. Yes.

Q. I see. And who were those physicians?

A. Do you really want me to answer that?

Q. Yes, ma'am.

A. Okay. Dr. Gurri was one of them. Dr. Bryan had a reputation for doing very complex surgeries. He had to use a lot of time. We used very delicate surgery instruments and very delicate suture material, and sometimes it was very hard to see, and it took a great deal of patience to do this. And some doctors, Dr. Gurri among them, did not want to spend that much time to do the procedure.

Q. So Dr. Gurri had a professional opinion that differed from that of Dr. Bryan?

A. Yes.

Q. And yet you call -- Is that a disparaging remark in your opinion?

A. As I said, it was not what was said, it was how it was said.

Q. Is that a difference of opinion in your mind, does that constitute a disparaging remark?

A. Not a difference of opinion, no.

Q. All right. Other than Dr. Gurri, who else in your opinion made disparaging remarks about Dr. Bryan?

A. I'd rather not say.

Q. Well, ma'am, as Mr. Moss indicated, this is a very serious matter.

to say well, I can't say whether he said this is A, B, and C or this is B, C, and D. It doesn't -- You know, the exact words used aren't that important as if you can remember the content of what he said, I want you to tell us. If you can't remember the content of what he said, then just say so and we'll move on to other questions.

A. Okay.

Q. Can you remember the content of anything Dr. Foley said that leads you to believe that he made disparaging remarks against Dr. Bryan?

A. Not right now I cannot.

Q. Okay. Is there any way you can go back and refresh your recollection? Did you keep any diary of what went on in the hospital on a daily basis?

A. No.

Q. Let me ask you the same question with respect to Dr. --

A. Armstrong.

Q. -- Armstrong, thank you. Can you remember the content of any statements you heard Dr. Armstrong make that can support your opinion that Dr. Armstrong made disparaging remarks about Dr. Bryan?

A. I remember Dr. Armstrong one day making a comment about how many cases Dr. Bryan was doing.

Q. Okay. Was it a comment or question, to the best

EXECUTIVE COMMITTEE

June 5, 1989

There was a called meeting of the Executive Committee on Monday, June 5, 1989 at 12:30 P.M. in the Physicians Dining Room.

Present were:

Joseph A. Gurri, M.D., Chairman
Barry A. Mills, M.D.
Lyle Saltzman, M.D.
Alfred Tortorelli, D.M.D.
James Hunt, M.D.
H. Phillips Stall, M.D.
Raymond A. Armstrong, M.D.
Norman F. Fain, M.D.
Scott Gettings, M.D.
Steven Eggen, M.D.
Pablo Enriquez, M.D.
Harris Cherin, M.D.
Scott Seminer, M.D.
Kirk Gray
Anita Lymburner
Michael D. Means
Elting Storms

Dr. Gurri called the meeting to order. He advised that this would be a single-issue meeting; namely, to discuss the recommendations of the Hearing Panel regarding the suspension of Dr. Floyd Bryan as recommended by the Executive Committee.

Dr. Gurri reminded the Committee that the recommendation of the Hearing Panel is an advisory one - it should be reviewed, the issues addressed and at that point the Committee can either

concur with and forward the recommendation of the Hearing Panel to the Board, modify and clarify their original recommendation according to the recommendations of the Hearing Panel, or go to the Board with their original recommendation. The Hearing Panel's recommendation is not binding upon the Executive Committee in their decision to reach a fair and reasonable recommendation.

Dr. Gurri quoted from the Bylaws, Article VIII entitled, "Hearing and Appeal Procedures", Section 43.9. entitled, "Burden of Proof" which reads as follows: "In all cases in which a hearing is conducted under this Article, after all the evidence has been submitted by both sides, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded."

and I do not remember the specific details, but there were cases that kept surfacing.

Q. So case by case they were not discussed?

A. That's right.

Q. So that it was an impression of the panel that was used to assess these incidents that had occurred prior to that episode?

A. That's right.

Q. Okay. And what was the impression of the panel as to their validity or their inaccuracy?

A. Well, it would appear from that testimony we could obtain that some of them were inaccurate.

Q. Okay.

A. And, therefore, making it open to question as to the validity of any of them.

Q. Okay. I'm going to stop there. Some were inaccurate, some were accurate?

A. Well, some were inaccurate, and it was very difficult to determine the accuracy of any of them.

DR. GOLD: Were the three, just the ones that you had, sufficient evidence to make a determination, out of all those that were provided or discussed?

THE WITNESS: Well, our determination, at least our charge of the determination, was

with any group.

Q. And at the regular meeting, you couldn't resolve what to do with the man; is that fair statement?

A. At the regular meeting or the special meeting, sir?

Q. At the regular meeting.

A. Which meeting is that?

Q. All right, sir, let me direct you to meeting of June 5th, 1989, the Executive Committee, and --

A. If I'm not mistaken, that was the special meeting.

Q. There was a called meeting of the Executive Committee, is that regular or special?
A. That's a special meeting.

Q. Okay, sir. All right, that was a special meeting where Dr. Gurri called the meeting to order.
A. Yes, I don't remember who was the Chairman at that time.

Q. Well, I have got the minutes in front of me. Let me hand you, sir, Defendant's Exhibit 103. Got that in front of you, sir?
A. Yes, sir.

Q. June 5th, starting at the top, Joe Gurri, Chairman, Barry Mills, Lyle Saltzman, Dr. Raymond Armstrong, Scott Gettings, Lymburner, Michael Means,

Elting Storms, Kirk Gray, about 17 people there, right?

A. Yes.

Q. Starts out, does it not, says Dr. Gurri called the meeting to order?

A. Yes.

Q. Single issue, meaning namely to discuss the recommendation of the Hearing Panel?

A. Yes.

Q. Dr. Gurri reminded the Committee that the recommendation of the Hearing Panel is an advisory one and should be reviewed. The issues addressed and at that point the Committee can either concur with and forward the recommendation to the Board, modify and clarify their original recommendation or go to the Board with their original recommendation. The Hearing Panel's recommendation is not binding upon the Executive Committee. Is that your understanding of the Bylaws?

A. Yes, sir.

Q. Dr. Gurri quoted from the Bylaws, hearing and appeal process, section entitled Burden of Proof. That basically says what we have been saying, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person

has proved that the recommendations was [*sic*] unreasonable, not sustained by the evidence. Is that correct?

A. Or otherwise informed.

Q. Or otherwise informed. Dr. Ryon came into the Hearing Panel. Dr. Ryon advised the Panel that they could support the recommendation of the Executive Committee except for several technicalities which existed, the failure of the subcommittee to discuss the incident reports, the imposition of a recommendation for a four-week suspension before Dr. Bryan had been allowed to appear before the full Executive Committee to discuss and the conclusion that Dr. Bryan had already sustained significant punishment and the reduction in patient load, expenses incurred, hiring an attorney, I'm sorry, and at the time spent in preparation for an attendance at the Hearing Panel meetings. Did I read that correctly?

A. Yes, sir.

Q. Dr. Ryon was further questioned and down in the middle of that paragraph, Dr. Ryon said it was the opinion of the Panel that the subcommittee mechanism and incident reporting procedure were flawed and that Dr. Bryan was not granted reasonable opportunity or appropriate methods of justifying his behavior. Speaking about that stuff, you remember that

[TEXT OMITTED; AS SUBMITTED BY HOSPITAL]

Dr. Gurri presented an update on Dr. Floyd Bryan's appellate appeal. The Board has made a decision recommending that no suspension of clinical privileges be given at this time, but that a strict monitoring program be set up to answer directly to the Board. If Dr. Bryan has any more serious incidents, his clinical privileges will be terminated (he will be monitored for one year). Every incident report will be reviewed by the Executive Committee with Dr. Bryan and will then be sent to the Board. Dr. Bryan will appear before the Board on October 19 to hear this decision.

Holmes Regional
Healthcare Systems

October 19, 1989

Dr. Floyd T. Bryan
1402 Oak Street
Melbourne, Florida

Dear Dr. Bryan:

The smooth operation of this hospital depends upon a professional and courteous relationship among physicians, nurses and other hospital employees involved in patient care, and hospital management. Your inability to work harmoniously with others has severely disrupted this balance and has diverted an inordinate amount of valuable physician leadership and hospital management time from vital patient care concerns.

The hospital's legal responsibility for the quality of patient care embraces the quality of medical care as well; and the hospital, therefore, has not only the right, but the duty, to establish and enforce standards of competence in physicians who practice in this hospital. The quality of care cannot be divorced from the hospital environment in which it is provided; and, therefore, we must require that all physicians, no less than hospital employees, meet reasonable standards of personal behavior in the hospital. Your disruptive behavior in this hospital, which has included verbal abuse and harassment of nurses and other hospital personnel, is a direct threat to patient care and cannot be tolerated.

Your right to practice at this hospital is only for so long as this Board grants you this privilege. You do not have the right to

act outrageously or in a disruptive manner when using this hospital and its facilities.

Your non-constructive criticism directed to nursing personnel and other employees has intimidated them, undermined their confidence, belittled them, and imputed stupidity, bad motives or incompetency.

Likewise, your negative comments on a patient's chart and to the patient and his family about other physicians, nurses, treatment being given or the operation of the hospital is a course of behavior which is inimical to the proper operation of this hospital and cannot and will not be tolerated.

This Board has both the right and the duty to assure itself that its Medical Staff will meet its standards of both professional performance and personal conduct to ensure the quality of medical care and efficient hospital operation. There is no reason to distinguish between poor clinical performance or poor behavior or conduct.

Nursing personnel and other support people are employed by the hospital to provide patient care and to assist you and other physicians in providing care for your patients. They are, however, employees of the hospital and under the direct supervision of the Administration. If you have a grievance about a nurse or other support person, your grievance should be directed to the Administration who has the ultimate responsibility for hospital personnel. You can be assured that if your grievance is well founded that appropriate action will be taken.

This Board is in agreement with the Medical Staff Executive Committee and finds that you have been guilty of inappropriate and disruptive professional behavior arising out of two

separate incidents involving personnel and patients at this hospital on October 24, 1988 and November 26, 1988.

Your pattern of disruptive behavior is well documented and has persisted over a period of years notwithstanding repeated oral and written warnings, and is clearly beyond acceptable standards of personal behavior and is a threat to patient care.

This Board has given due consideration to the report of the Hearing Panel of the Medical Staff and is cognizant of the many hours that they devoted to this matter, and in deference to them has accepted their recommendation and the recommendation of the Board Review Panel that a temporary suspension of your clinical privileges not be imposed at this time although we believe the disruptive impact of your behavior warrants corrective action.

It is clear to the Board that the need of the hospital to carry out its primary obligation in providing patient care in an atmosphere of calm, order and respect for the dignity of all should not be sacrificed to your disruptive proclivities. Because of your long history of disruptive behavior and the need for the hospital to act, should there be any further disruptive or unacceptable behavior your privileges are subject to revocation. Effective immediately, the following action will be taken.

1. The Executive Staff Medical Committee shall be required to establish and maintain an on-going mechanism to monitor your behavior and actions, including the requirement that you continue to receive professional counseling.

2. All incident reports involving you or your patients shall be reviewed by the Medical Staff Executive Committee

and shall be submitted to this Board for our review through the Joint Conference Committee for a period of not less than twelve (12) months and until such time that no incident reports have been filed for twelve (12) consecutive months.

3. This course of action is being taken based upon receiving your assurances that you will abide by these recommendations and sanctions.

4. You are advised that any further display of unprofessional and disruptive conduct will not be tolerated and will result in the permanent suspension of your clinical privileges at this hospital.

On the enclosed copy of this letter, please acknowledge your agreement to abide by the sanctions and recommendations as set forth herein.

AS PRESENTED BY THE BOARD OF DIRECTORS
HOLMES REGIONAL MEDICAL CENTER

I HEREBY ACKNOWLEDGE RECEIPT OF A COPY OF THIS LETTER AND AGREE TO ABIDE BY THE SANCTIONS AND RECOMMENDATIONS AS SET FORTH HEREIN.

Please see cover letter 13 Dec. (handwritten note from Dr. Bryan)

/s/ F. Bryan
FLOYD T. BRYAN, M.D.

RPS/gkb

Floyd T. Bryan, M.D., P.A.
GENERAL AND VASCULAR SURGERY
1402 OAK STREET
MELBOURNE, FLORIDA 32901
(305) 724-8667

DEC 18 1989

December 13, 1989

Russell Sullivan, Chairman
Board of Directors
Holmes Regional Health Care Systems, Inc.
1350 S. Hickory Street
Melbourne, FL 32901

Dear Mr. Sullivan:

Thank you for providing two copies of your October 19 letter. It was most convenient. Enclosed find one signed copy.

I must firmly reiterate my position that I was not guilty of "disruptive behavior" on October 24 and November 26, 1988. The Hearing Panel, the only group ever to hear both sides, supports this position. Furthermore, the "pattern of disruptive behavior" was shown, again by sworn testimony, to be largely erroneous or frivolous while "repeated warnings and counseling" were non-existent with the notable exception of Dr. Stall's advice.

Finally, as I pointed out in the October 19 Board meeting, the last sanction declaring "permanent suspension" for "any further display" is unrealistic and impossible.

As stated in previous letters, I desire to serve this community by practicing quality vascular surgery - all the rumors,

slanders, and expense generated by this problem notwithstanding. As my practice depends entirely upon the generosity of the Board, I pledge to abide by its recommendations to the best of my ability. By signing I do not waive or restrict my rights to due process of law or other civil rights as a medical staff member and American citizen.

My Best Wishes for a Merry Christmas and hopefully a better New Year.

Sincerely,

/s/ Floyd Bryan

Floyd T. Bryan, M.D.

cc: George Moss

Q. Let he ask you to assume, sir, that it is the letter that finally came out following the Ryan [*sic*] panel which set certain parameters for conduct for Dr. Bryan. Would you assume that for me, sir,
hypothetically?

A. Okay, yes.

Q. Directing your attention, sir, to the second paragraph or your first paragraph, it says your inability to work harmoniously with others has severely disrupted the balance, this is the first paragraph of the letter.

A. Okay.

Q. That wasn't the finding of your hearing panel, was it?

MR. KAY: Let me just object, Your Honor. He's already testified what the narrow scope of his hearing panel was and what their findings were.

A. No, I don't think it was.

THE COURT: Overruled.

Q. I'm sorry.
A. No, I don't think that was the finding of our panel.

Q. All right, sir. And the whole basis, if you've read through this letter or skimmed, let he ask you to assume that it speaks about a long history of

disruptive behavior. Was it the finding of the Ryan [*sic*] Panel charged to hear the evidence in this case that Dr. Bryan had a long history of disruptive behavior?

MR. KAY: Objection to the form of the question. It's leading, it's also outside the scope.

THE COURT: Overruled.

A. No, that was not the finding of the panel. That was not our charge.

Q. Directing your attention to the fourth paragraph, it reads, does it not, your non-constructive criticism directed to nursing personnel and other employees has intimidated them, undermined their confidence, belittled them and imputed stupidity, bad motives or incompetence. Did you find any evidence that Dr Bryan set out to practice medicine in that way?

A. No, I don't think so, but I don't think there's any physician on the staff at Holmes Medical Center that hasn't said some things to personnel at the hospital that they later regretted.

Q. All right, sir.

A. But that was not our job to judge him.

Q. And the last paragraph that speaks about a negative comment on the chart, do you recall asking question after question of witness concerning

doctors whether or not it was right to write the truth down on a chart, even if it involved criticism of other doctors or nurses?

A. I remember that.

Q. Did you find that Dr. Bryan's writing the truth or what he thought was the truth on the chart was inappropriate behavior?

A. I'm not sure it was wise, but neither am I sure it was inappropriate.

Q. All right, sir. Thank you. And continuing with the letter, do you recall, sir, testimony submitted by Dr. Bryan, by me through Dr. Bryan concerning his attempts to correct nursing personnel that weren't meeting his standards?

A. Yes.

Q. Was he given any satisfaction?

A. No.

Q. Continuing, the Board is in agreement with the Medical Staff Executive Committee and finds you have been guilty of inappropriate and disruptive -- well, we've already asked that. How about this one, your pattern of disruptive behavior is well documented and has persisted over a period of years, notwithstanding repeated oral and written warnings, and is clearly beyond acceptable standards of personal behavior and

is a threat to patient's care.

Let me ask you to say, sir, that you're the only panel that's ever heard Dr. Bryan's side of some of these incident reports. Was that your finding?

A. No.

Q. Doctor, finishing up the letter, number four, would you read that one out loud, sir?

A. You are advised that any further display of unprofessional and disruptive conduct will not be tolerated and will result in the permanent suspension of your clinical privileges at this hospital.

Q. Being present at the hearing panel, did you find any reason where a punishment such as that should be imposed on Dr. Bryan? Was that the recommendation of your committee?

A. No, it was not.

Q. Was it even the recommendation of the Medical Executive Committee as best you know?

A. Well, I really I don't know what went on in that committee. I can't attest to that.

Q. In essence, does that -- well, it says what it says, Your Honor, I'm sorry.

When you read that the hearing panel does not condone the actions of Dr. Bryan, would you explain to the jury what in your opinion that means?

MR. KAY: Objection. Just calls for speculation on the part of this witness and it's written by Dr. Ryan [*sic*], not by this witness.

THE COURT: He can give his opinion as a member of the panel what his findings were.

A. Well, I think that what Dr. Ryan [*sic*] wrote was the consensus opinion of the panel.

Q. And what was your understanding?

A. My understanding was certainly nobody condones actions that are disruptive, that cause problems on the floor, in the operating room, anywhere, but as I recall, we were, we were impressed by the lack of fairness in this whole procedure.

MR. KAY: Objection, move to strike.

THE COURT: Overruled.

A. That's not to say that Dr. Bryan doesn't have some problems. I guess if he didn't have any problems, we wouldn't be here. We all have problems. It's a matter of degree. Our panel did not feel, as I recall in speaking for them, that any one incidence was of sufficient magnitude to result in the punishment that he received, nor did we feel that the method in which the incidents were reported and dealt with were properly done, and as a result of that we did not feel that perhaps the sum total was worthy of the actions

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OFFICE OF THE CLERK

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1994

FLOYD T. BRYAN, and
FLOYD T. BRYAN, M.D., P.A., Petitioners,

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,
Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

VOLUME II

Jennifer S. Carroll
Metzger, Sonneborn & Rutter, P.A.
1545 Centrepark Drive North
West Palm Beach, Florida 33401-7414
(407) 684-2000
Counsel of Record

George H. Moss
Moss, Henderson, Van Gaasbeck,
Blanton & Koval
Post Office Box 3406
Vero Beach, Florida 32964-3406

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DOCUMENTS PURSUANT TO RULE 14.1(k)(i)-(iv)

Opinion - (Bryan v. HRMC, 33 F.3d 1318 (11th Cir. 1994)) A.1-52

May 20, 1992 Order on Summary Judgment, U.S. District Court, Middle District A.53-73

August 27, 1992 Post-Trial Order, U.S. District Court, Middle District A.74-81

July 7, 1992 Motion for Judgment as a Matter of Law Pursuant to Rule 50(b), U.S. District Court, Middle District A.82-86

December 9, 1994 Order Denying Petition for Rehearing, Eleventh Circuit Court of Appeals A.87-89

June 22, 1992 Judgment, U.S. District Court, Middle District A.90-91

June 17, 1992 Special Verdict Form, U.S. District Court, Middle District A.92-93

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Document — Reference

EXCERPTS FROM RECORD ON APPEAL

Excerpts of Trial Transcripts (pp.535,1112) A.94-95

Curriculum Vitae of Floyd Talmadge Bryan, M.D; Excerpt of Trial Transcripts (p.809); Excerpt of May 20, 1991 Deposition Transcript of Olivia Ayers, R.N. (pp.35-36); Excerpt of February 19, 1998 Executive Committee Minutes. A.96-106

Excerpts of Trial Transcripts (pp.2741-2742; 2783) A.107-108

Special Verdict Form submitted by Defendant James E. Holmes Regional Medical Center regarding Health Care Quality Improvement Act A.109

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Q. And do you continue to be Chief of Surgery?

A. Yes.

Q. Are these elections contested like, I mean do you have a Ross Perot that pops up or do you just get elected every year?

A. Anybody had that much money, they wouldn't run for Chief of Surgery.

Q. Have you ever been opposed as Chief of Surgery?
A. No.

Q. Do you also hold a position on the Board of Directors of the hospital -- is it Board of Directors or Board of Trustees? Which is right?
A. Your choice; we usually say Board of Directors.

Q. Are you a director of the hospital?
A. Yes.

Q. How long have you been a director of the hospital?
A. Since I believe 1986.

Q. What are your duties as the director of the hospital?

A. As a director of the hospital, to sit on the Board of the hospital, to hear the business of the hospital and enact on business that comes before it.

Q. And in your capacity as a director of the hospital then, is your involvement more in the

vascular surgery at Holmes Regional Medical Center?

A. Again, Dr. Armstrong wins with five hundred and forty four, he's the highest number, and I am the second highest with five hundred three with pretty close range, Dr. Jackosn, [*sic*] four ninety, Dr. Tenewitz, four hundred and ninety six.

Q. All right, sir. Moving on, sir.

Dr. Gurri, you have in the past attended, based upon your positions at Holmes Regional, and just so that we have this all put together, up until today what positions have you held of authority for the medical staff or on the board?

A. I was Secretary Treasurer of the Medical Staff, Vice President of the Medical Staff, President of the Medical Staff, subsequently serving on the Executive Committee for two years as immediate past President.

Q. And have you become a member of the Board at any time, Board of Directors?

A. No.

Q. Have you appeared from time to time before the Board?

A. The Chief of Staff appears on the Board.

Q. So the answer is yes?

A. Well, he's not a member of the Board. He

attends the board meetings, but he's not a member.

Q. That was my question. You have appeared in that capacity before the Board of Directors?

A. That's correct.

Q. All right. Now, sir, you have attended seminars dealing with the issues of due process, conspiracy, fair hearing, adherence to the by-laws, you have done that in the past, haven't you, sir?

A. I have attended medical staff issue education courses that did cover these subjects.

Q. And in fact, you attended one in 1987 in Santa Fe, New Mexico, isn't that correct?

A. That's correct.

Q. And who went with you sir?
A. Mr. Wilford, who was the President of the hospital, the administrator of the hospital, Mr. Storms, Dr. Foley. Oh, and Mr. Sullivan, Mr. Sullivan went too.

Q. And who paid for the seminar, the trip, the lodging?
A. The hospital did.

Q. And who put on the seminar?
A. It was the law firm of John Horty.

Q. The law firm of Horty, Springer and Mather in Pittsburgh, Pennsylvania, correct?

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?

A. Uh-huh.

Q. That's a yes?
A. Yes, yes, I'm sorry. Yes.

Q. And the same one that had yelled at you?
A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.

Q. Did they ever lose their staff privileges?
A. No.

Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are they powerful politically?
A. Yes.

MR. KAY: Objection.
BY MR. MOSS:

HOLMES REGIONAL MEDICAL CENTER

General Surgery
1988 - 1991

Physician	1988	1989	1990	1991
Ali	58	79	86	56
Alper	.	.	161	93
Armstrong	376	450	502	544
Bryan	171	145	85	.
Collins	.	.	115	264
Gurri	309	292	427	495
Jackson	866	708	841	490
Patel	292	348	409	325
Shamma	.	.	0	11
Tenewitz	309	333	354	416
Vitale	300	320	362	359
TOTAL	2681	2675	3342	3053

HOLMES REGIONAL MEDICAL CENTER

General/Vascular Surgery

1988 - 1991

Physician	1988	1989	1990	1991
Ali	71	91	104	67
Alper	.	.	161	96
Armstrong	376	450	502	544
Bryan	314	239	122	.
Collins	.	.	156	318
Gurri	345	340	461	503
Jackson	866	708	841	490
Patel	292	348	409	325
Shamma	.	.	162	329
Tenewitz	386	435	484	496
Vitale	366	378	433	405
TOTAL	3016	2989	3835	3573

Q. All right. Now, let's start off in 1988. How many General Surgeries did Dr. Gurri, yourself, do in 1988?

A. Three hundred and nine.

Q. How many did Dr. Bryan do?
A. One Hundred and seventy one.

Q. And how many did Dr. Armstrong do?
A. Three hundred and seventy six.

Q. Moving on, same question, 1989. How many did Dr. Gurri do?

A. Two hundred and ninety two.

Q. Dr. Bryan.

A. One forty five. Dr. Armstrong, four fifty.

Q. 1990, same question, please.
A. I did four hundred and twenty seven. Dr. Bryan eighty five. Dr. Armstrong, five hundred and two.

Q. 1991, please, sir.
A. I did four hundred and ninety five. Dr. Bryan did none. Dr. Armstrong did five hundred and forty four.

Q. Who were the top two performers of General Surgery according to this document in the year 1991 at Holmes Regional Medical Center?
A. Dr. Armstrong with five hundred and forty four and I beat out Dr. Jackson by five cases with four

hundred and ninety five.

Q. How much of an increase, Dr. Gurri, according to this document, was there between 1988 when you did three hundred and nine and 1991 when you did four ninety five?

A. That's a hundred and eighty six cases.

Q. More?

A. More.

Q. And how about Dr. Armstrong, same question, how many more did he do comparing '88 to '91, how many more?

A. Sir, I don't have the calculator, it's not fair, but --

Q. Well, it's just five forty four, subtracting three seventy six, how many is that?

A. A hundred and sixty six. A hundred and sixty eight.

Q. Third page, sir. What's that entitled?

A. General/Vascular Surgery, Holmes Regional Medical Center, 1988, 1991.

Q. All right, sir. Same procedure.
A. 1988.

Q. Yes. How many did Dr. Gurri do?
A. Three hundred and forty five. Dr. Bryan, three hundred and fourteen. Dr. Armstrong, three hundred

and seventy six.

Q. Same question, please, for 1989.

A. Dr. Gurri, three forty. Dr. Bryan, two hundred and thirty nine. Dr. Armstrong, four hundred and fifty.

Q. Same question please, for 1990.

A. Myself, four hundred and sixty one. Dr. Bryan, a hundred and twenty two. Dr. Armstrong, five hundred and two.

Q. And for 1991, same question.

A. Myself, five hundred and three. Dr. Bryan, none. Dr. Armstrong, five hundred and forty four.

Q. Dr. Gurri, how much increase was there between 1988 and 1991 as to Dr. Gurri by way of increase in the number of procedures, General Vascular Surgery, at Holmes Regional?
A. A hundred and fifty eight.

Q. And how about the same question by way of increase as from '88 to '91 for Dr. Raymond Armstrong?
A. Again, the same. The same as the previous figure.

Q. And you said that Dr. Bryan obviously did none in 1991?
A. That's correct.

Q. Who were the top two as of 1991 as doing General

Stark?

A. I have worked with Tina Stark on surgery cases and she is a surgical tech and I don't think that she's a good surgical tech.

Q. Why not?

A. I don't think that she pays attention to the cases and I think that she's slow. And I have found her personally difficult to work with, because she just doesn't have things ready on the spot when you need them. And I find her inattentive.

Q. And I see that this incident report signed by Tina Stark is typed. Does it appear a little unusual one way or another to you?

A. These are both typed? These are both typed.
Q. Yes.

A. I have no idea who typed them.

Q. All right. Now, on to the next one, on the next one, that's the Tina Stark and you have given us your opinion on that. Let's go to the next one. In time I'll do these in chronology. The next one is March the 11th, 1990. And I'll ask Mr. Donahue to pass number 83 for counsel on up to you. Will you please take a look at that. Just scan that because I believe you have reviewed these before. And I think I can summarize this as being a misdirected patient, and

I think.

Q. Now, have you worked with the Complainant, the woman who signed the incident report?

A. Michael Green?

A. Yes.

Q. Again, the same question I asked you about Tina Stark, your impressions about the ability of Michael Green.

A. I did not work with Michael as much as I had worked with Tina, and there are certainly people in the O.R. with whom you develop a rapport right away and others with whom you do not. I didn't think he had a good attitude toward his work and I also felt that he was somewhat inattentive. But that was only on a few occasions. I didn't work with him that often.

Q. Now, just briefly, have you worked with Dr. Gurri?

A. Yes.

Q. Does he perform, in your experience, does he perform the same type of surgery as Dr. Floyd Bryan?

A. I believe so.

Q. Does he perform the serious type of operations or deal with serious sick patients --

A. Yes.

A. No, not with Lynne Stoldt, no.

Q. With whom?

A. I believe Monica Utz (ph).

Q. Do you know a Lynne Stoldt?
A. Yes, I do.

Q. Were you told that you would not be recommended for rehiring by Holmes Regional Medical Center?
A. No, I was not.

Q. You did have an exit interview, didn't you?
A. Yes, I did.

Q. Did you say that you were unhappy and that all aspects, about all aspects of your job, that you came from the military and felt something about too accommodating here, at Holmes?

A. No, I believe in my exit interview, I was asked by Miss Utz to indicate why I was unhappy with the clinical situation, you know, as an operating room nurse at Holmes, and I told her that I'd had some problems with staffing. With the scheduling process, that I felt that we, the patient load was periodically too heavy for the staffing, for the workload. I also had some problems with mid management not being supportive enough with the three to eleven staff. And I believe I would not necessarily agree with what you just read. There was an at-length statement as to why

that I gave in my exit interview why I was unhappy clinically with my job situation at Holmes. And I gave that in confidence in an exit interview.

Q. Well, I have been provided a copy of that.

A. Yes, sir, I know you have.

Q. May I approach the witness, Your Honor? Is this a copy of the exit interview for Michael G. Greene, giving your social security number, last day of employment, July 26, 1990, evaluator, Lynne Stoldt, RN, BS, Assistant Vice-President?

A. That's not the form that I saw when I was making an exit interview, no. I think that was the form that was made out by Ms. Stoldt after the fact.

Q. Would you read this here, publish this? Would you recommend this employee for rehire? What does it say?

A. MR KAY: Object, calls for hearsay. It is not his report, it is another nurse's.

THE COURT: Sustained.

Q. Now, sir, as to your testimony before the Dr. Chanda Panel, who asked you to testify before the Dr. Chanda Panel?

A. I believe I was asked by, it's been so long ago now. I believe I was asked by the hospital attorney, Mr. Storms.

Look at the first page there, Dr. Guy, so that we put all this together. The date of that incident report, looking at the top left-hand corner or about a third up there is dated March 7, 1990; is that correct?

A. Yes.

Q. And if you look at the bottom right corner, the date of the actual incident report signed by Tina Stark and Jane La Casse is dated March 13, 1990.

A. Yes.

Q. A period of six days. Now my first question to you is, is there any rule within the hospital which requires that incident reports be filed within 24 hours of the incident?

A. I'm not sure. I don't know that.

Q. In any event, have you now reviewing this incident report involving Tina Stark and Jane La Casse and of course Dr. Bryan that involved a Fogarty catheter, and we have been through this this morning as far as the Fogarty catheter and things of that nature. Having read what you just read, this is, the incident report of March 7th, 1990, which we'll call the Tina Stark incident report, do you see anything in there which would warrant taking Dr. Bryan off the staff permanently?

A. No.

A. Yes, I did.

Q. Did you also prepare an incident report on Dr. Bryan's behavior against Tina Stark?

A. Yes. At the end of the case Tina and i got together and with the intentions being the circulating nurse normally is the person because they're licensed fills out the appropriate paperwork.

Q. Would that be you?

A. That would be me. And we got together, made sure of the, confirmed the situation and the sequencing and wrote down a draft. Tina wrote the draft as we were both discussing the sequence of the case.

Q. The next day did you give an oral or dictated report?

A. I'm not certain if it was exactly the next day. I do know that the incident report for the leg was turned in that night and the, I turned that in, and Tina turned in the rough draft that night. The following day we were called before our three to eleven shift, Judy Bourne had talked to us and then we all were called to Lynn's office.

Q. And who is Lynn?

A. Lynn Stoldt is the Vice President of Nursing in the operating room.

Q. And did you give a more detailed report after your meeting with Lynn Stoldt?

A. Yes. Lynn asked us to each tape an incident report and a sequence of events as best as we could understand.

Q. Did you tape that report in a room by yourself?

A. Yes, yes, we both did.

Q. And then was that report typed up?

A. Yes, it was.

Q. Now, there's been, handing you what has been marked as Exhibit Eighty Two, is that in fact your report as you dictated it?
A. The second page that starts with the report prepared by myself, yes, that's it. That's mine.

Q. And in that report do you reflect as you testified today that Dr. Bryan made the statement, the patient is bleeding because you did it wrong?
A. Yes.

Q. After Tina had said don't you hit me?
A. Tina said don't you hit me, yes.

Q. And your report also reflects that he, as you've testified, I want it this way every single time, leaning over looking over at Tina over his loops and asking Tina the question three different times, each time his voice getting deeper, don't you?

A. That's correct.

Q. By the way you also indicate it's very frustrating to work with him when he was not in control. At that point in time do you feel that Dr. Bryan was displaying evidence that he was not in control?

A. Yes, I do.

Q. Now, there's been some question about this document reflecting that the incident occurred on 3-7-1990, but looking at the first page it indicates that the date of it is 3-13-90. Could you tell the jury, I believe the event occurred on 3-7. When did you get an opportunity to review that which you had dictated in a typed form?

A. It was sometime the following week. There was a weekend involved from what I can remember and I believe that the tape report was done on Thursday, I can't remember exactly if it was Thursday. I do know that the tape recorder stayed in Judy Bourne's office over the weekend and there was someone that was supposed to type the report.

Q. Judy Bourne or Lynn Stoldt?

A. It was in Judy Bourne's office where we left the tape.

Q. And then after the tape was transcribed, did

they provide a copy for you to read?

A. This copy, yes, was the primary copy. We read and then we were asked to sign.

Q. But when you dictated this occurred shortly after the event?

A. Yes, it did.

Q. Now, you had indicated that you had prepared something the evening before. Was it your idea to prepare an incident report?

A. Most assuredly.

Q. Did anybody in the Hospital tell you to prepare the incident report?
A. No.

Q. Excuse me. Go ahead.
A. I'm sorry for interrupting. That is, again, a standard of practice that a registered nurse, a circulating nurse would do for any unusual occurrence in the room would be to write an incident report. It is also Hospital policy.

Q. Why did you believe an incident report should be filed here?
A. I believe a slap is most definitely an unusual occurrence.

Q. Have you, did you believe this was an inappropriate and abusive behavior on the part of Dr.

MR. KAY: Your Honor, again objection. May I approach?

MR. METZGER: Your Honor, I'll withdraw the question.

MR. KAY: I'd like to approach, if I may.

THE COURT: He withdrew the question. No reason to approach.

MR. KAY: Your Honor, I just request sidebar at this point.

THE COURT: There's no record.
MR. KAY: Okay.

BY MR METZGER:
Q. When did you review this statement of March 28, 1990 by Gene Gonyaw?
A. This was supplied with the incident report.

Q. All right. Let's just go through the chronology now. This event, alleged event occurred on what date?
A. March 7, 1990.

Q. March 7, 1990. And you filed your incident report six days later, that is, the typed incident report on the 13th, correct?
A. No, sir. I would like you to re-ask the question and I did not supply my incident report at that later date. I filled out the incident report about the leg falling off the table the night of the occurrence and

We also had, Tina and I had filled out a preliminary report that night and turned both of those in the night of the occurrence.

Q. I'm looking at the incident report. Do you have the incident report in front of you of March 13, 1990?

A. Yes, I do.

Q. And so that we're all looking at the same thing, does that have a number on it?

A. The very first copy says Exhibit number eighty two.

Q. Thank you. Now, referring to Exhibit number eighty two, would you just look at the first page and tell us the date that Tina Stark, O.R.T., and Jane LaCasse, R.N., signed this incident report? Isn't it March 13, 1990?

A. I would say not necessarily true, sir. And the reason I say that is we signed it but we did not date it. We did sign, in fact.

Q. Well, doesn't the first page show that this document, this incident report of this alleged incident was signed by you and Tina Stark on the 13th day of March, 1990? Yes or no?
A. No.

Q. When was it signed?
A. I can't tell you the exact date. I can tell you

that yes, it was signed, and I can only refer to the date that it was, the date that's at the bottom that it was typed.

Q. All right. Let's just run through this now. You said you signed, you prepared -- first of all, when you heard this alleged slap you picked up a piece of paper and a pen and you started to write in the operating room?

A. Yes, sir.

Q. And the operation was going on?

A. Yes, it was. And that's why I picked up the pen and paper.

Q. And you were the circulating nurse for this patient?
A. Oh, yes.

Q. This was an aneurism?
A. False aneurism of the right groin.

Q. That can be fatal, can't it?
A. No, it cannot be. An abdominal aortic aneurism can, but a femoral aneurism, not fatal.

Q. Not fatal. Well, what if it bursts?

MR. KAY: Objection, Your Honor. there is no evidence to this in the record.

THE COURT: Overruled.

Q. What if this aneurism which is already gone into

format, and often times we write down an anecdotal note form and that was what we did. That's what we're calling our rough draft or our preliminary, that was the anecdotal note format.

Q. Had you ever done a preliminary draft before?

A. I have on other occasions.

Q. And what did you do with this preliminary draft or this anecdotal thing?
A. Tina turned it in.

Q. To whom?

A. We both put it in a signed box where we we're supposed to turn in incident reports. She turned in that report and I turned in the one that I had completed on the leg having fallen off the table.

Q. So there were two incident reports, one about the leg falling off the table and one about the alleged slapping?
A. Yes.

Q. And you just put them in a box?
A. In a slot like mail box, a signed mail box, yes.

Q. And to whom, what person was that directed?
A. That generally is reviewed by Judy Bourne who is the Nurse Manager, and then from there often times they're also reviewed by Lynn Stoldt, the Vice President of Nursing in the operating room.

Q. Do you know by whom it was in fact reviewed, the preliminary or the anecdotal report?

A. To the best of my understanding Judy Bourne had read it the following day, and when Tina and I came in to our three to eleven shift she had directed us to go to Lynn Stoldt.

Q. And then you went to Lynn Stoldt and according to my notes you then took a tape recorder and then you did another incident report which you dictated?

A. Yes. Lynn asked us to dictate, for each one of us to individually dictate a report.

Q. All right. And what you dictated is what we have here in front of you, this three page typed report by Jane LaCasse which is attached to the incident report dated March 13, 1990, correct?
A. Yes.

Q. Who typed this?
A. That I don't know.

Q. What happened to the one you wrote out?
A. I didn't write it, per se. Tina was writing it.

Q. I thought there were two, one that you wrote and --
A. The one that I wrote was turned in, and when we talked to Lynn the following day I did in fact see her with it because she asked me about that as well.

Q. Now, do you have your typed report which is dated, which you signed apparently on March 13 or sometime before, on or before March 13, 1990? Do you have that in front of you?

A. Yes, I do.

Q. As number eighty two?
A. Yes.

MR. KAY: Objection to mischaracterization regarding her prior testimony.
THE COURT: Overruled.

Q. All right. Would you just please help me as we go through this? Do you have page one there?
A. Yes, I do.

Q. And just so we're all on the same one, it's three pages, isn't it?
A. Yes, it is.

Q. And the last page has Jane LaCasse, R.N., and it has your signature, doesn't it?
A. Yes, it does.

Q. And on the front page it also has your signature, doesn't it, one dated 3-13-90?
A. On the official incident report form, yes.

Q. All right. Now, to your three page typed report. If you'll just follow with me, I have a few questions. You say Tina Stark was the scrub nurse and

Do you have a copy of that?

MR. KAY: No, I don't believe it's ever been requested. Not in this case. Doesn't involve Dr. Bryan's behavior.

Q. Now, have you reviewed the typed report prepared by Tina Stark?

A. Yes, I have.

Q. What's the date of it?

A. Incident involving Dr. F. Bryan on 3-7, 1990.

Q. And on the first page, Tina Stark signs this on March 13, 1990; correct?

A. Again, sir, I'm not certain that we signed it on the 13th. I know we signed it, I don't know when.

Q. All right. Do you have that in front of you, her report?
A. Yes, I do.

Q. Just a few questions on that. Now, the middle of the page, and this is approximately 20 lines down, it says, and I'll be happy to point this out to you. It's about halfway down, Mrs. LaCasse. It says the Fogarty catheters were lying on the back table. Do you see that?
A. Uh-huh.

Q. And Lee before she left -- are we referring to the one and the same Lee Dunham?

A. If I had the operative record in front of me, I would be able to tell you more accurately. I believe that I recall the incision was at 5:02. I know I took the patient to recovery room at 5:50. I cannot recall exactly the closing time of the case. It was somewhere between 5:40, 5:45. But again, unless I have the operative record in front of me, I don't remember when it finished.

Q. Well, we haven't been supplied that, so we'll just have to go on your memory. That's your best recollection; correct?

A. Yes.

Q. Now moving on, you did tell us that you testified under oath before that Dr. Joseph Chanda Panel; is that correct?

A. Yes, I did.

Q. Do you recall the date you testified?

A. No, I don't. I know the month was August. And the year was 1990. I don't recall the date.

Q. All right. Now when you gave the tape report which then was to be typed, you gave it because you were unsure how to report it accurately, in an accurate way?

A. I wanted to be sure that the sequence of events were accurate and Lynne asked us to tape the report.

As she was reading our preliminary report, she felt that we may not have had all the sequence of events and she wanted us to be accurate. So she did ask us to tape the report so that we could individually recollect the entire case as much as possible.

Q. When you gave the typed report, were you unsure how to report it accurately?

A. It was unnerving to have had a nurse slapped and therefore there was a lot more emotion, emotion on my part attached to this unusual occurrence.

Q. Yes, Ma'am, but my question was, when you gave the typed report, were you unsure how to report the alleged event accurately?

A. No.

Q. Page 250, Chanda Panel, under oath, August 8, 1990, Line 7, Question, can you relate to the Committee how it happened that the incident occurred on the 7th and the report was not signed until the 13th? Answer, your answer, we gave a taped report, being unsure how to report it accurately. Both Tina and I and we had collaborated to make sure that we were saying, what we were saying was to the best of our knowledge accurate. I did in fact make an additional report that evening to cover possible injury to the patient's leg.

Was that your answer at that time on August 8th?

A. It sounds like it. If I had a copy of the Chanda Hearing in front of me, I'd be more than glad to read along with you.

Q. Incidentally, where did you read the Chanda transcripts?

A. They were mailed to me within this last week.

Q. So you had plenty of time to read it?

A. I'm sure they could be said that way.

Q. Now, was there any injury, bruise, mark, discoloration, bleeding involving the hand of Tina Stark after this was all over?

A. I don't know, sir. I didn't look. I don't know.

Q. You didn't look. It wouldn't be important one way or the other? Correct?
A. To her it would be important and I'm sure she followed through because it happened to her.

Q. Did she have any injury that you're aware of?
A. I have no way of knowing.

Q. Well, when you taped the report the next day, she wasn't wearing gloves, was she?
A. I didn't look at her hands.

Q. Now was this a small case?

come off the table. So we were, we just sat down at the table and wrote them out. That's basically it.

Q. The next day when you came in, did you meet with anybody regarding the incident?

A. Yes, I met with Lynne Stoldt, who is our, I guess her title would be Assistant Vice-President of Nursing. I think that's correct. And she recommended at that time that since I was, I was very upset and very adamant about this is not acceptable behavior, that she suggested at that time that I, that I give a report over, she had a small recorder, and I didn't have a chance, that would have been Thursday, I didn't have a chance at that time to do it because we were real busy. And she says, well, you can just do it the next day. So I did it Friday.

Q. When you gave this report into the dictation equipment, was anyone else in the room?

A. No, no one else was present.

Q. You said that you were upset. Did you express anger or upset, the fact you were upset to Lynne Stoldt?

A. Yes.

Q. And why were you upset?

A. I had never, I had never, this has never happened to me before and I, I didn't quite know how

Q. All right, now, the incident report that you have there in front of you, what's the date of it on the first page?

A. Are you relating to Gene's incident report or my own?

Q. No, I'm sorry, I apologize. I mean to ask you, what is the date of your incident report, the first page when you signed it?

A. It says on the front page, report prepared by Tina Stark, ORT, regarding incident involving Dr. Bryan on 3-7-90.

Q. What's the day you signed it? Look on the bottom right corner. First page.

A. There is nothing on there, sir.

Q. The first page.

A. That is the first page.

Q. The first page on the incident report.

A. Down here, 3-13-90.

Q. Can you explain why you signed this incident report on 3-13-90 when the incident occurred back on March the 7th, '90? That is a difference or an interval of six days from March 7, 1990 until this incident report of March 13, 1990.

A. Well, this is the, this would have been that typed one we talked about earlier. And I was asked to

give it on a dictaphone and I believe, March 7th was a Wednesday, the 8th would have been Thursday. I gave, my dictation would have been on the 9th, which would have been Friday. And that means, and I didn't do it till my regular scheduled shift, which is in the afternoon. I don't believe I did it until like six or seven at night. So it sat in the drawer all weekend. So that would have been the 10th and the 11th would have been Saturday and Sunday. The 12th would have been Monday and that was probably when it was typed up. And then it was typed up Monday, I didn't see it probably until either Monday or Tuesday.

Q. Now, after this alleged event occurred on March 7th, 1990, did you and Jane LaCasse discuss it?

A. The event itself?

Q. Yes.

A. Probably the only discussion occurred while we jointly were making out the incident reports, which would have been that evening on March 7th.

Q. So then both of you prepared handwritten incident reports on March 7th, 1990?
A. Yes.

Q. And what did you do with your handwritten incident report of March 7, 1990?
A. I put it in, we have these outside of the O.R.

Q. All right. At that point to your knowledge had an incident report been filed?

A. Not to my knowledge.

Q. All right. Was anything said to you about Mr. Greene about being hit or struck with a suction device?

A. Yes.

MR. KAY: Objection. Calls for hearsay.

MR. MOSS: Okay.

THE WITNESS: Yes. He mentioned the fact that Dr. Bryan had rapped him on the knuckles or the hand.

BY MR. MOSS:

Q. Okay. And how did he characterize that to you?

A. He characterized it to me as it was no big deal.

Q. At some point later were you aware that he wrote an incident report?

A. Yes, I was so informed.

Q. Okay. And when did you learn that?

A. About a week later, I believe it was.

Q. And then since that time did you talk with Mr. Greene about the reason that he wrote up an incident report?

A. No, I didn't.

Q. Now, do you have an opinion, based on being an operating room person, a nurse in the operating room since 1978, have you become aware as to whether there is an

The system was flawed?

A. I don't think any of them were false in that somebody just made up a story. I think some of them you couldn't verify, some of them nobody knew anything about. Some of them were frivolous. Some were frankly silly. But the system was so fouled up that nobody could tell anything about a lot of them.

Q. So the Executive Committee, Defendant's Exhibit 104, the Minutes of June 12, voted to instead of no punishment, give you what?

A. Two weeks punishment.

Q. Did we appeal?

A. Yes, sir.

Q. Did you appear before the Board of Trustees with me?

A. Yes, sir, I was there to answer questions, I wanted to be there to answer.

Q. There was no transcript of the proceeding?

A. No, sir.

Q. Did I make the same arguments that I have made here today, that you hadn't been contacted and you didn't have the ability to respond to the charges, that the Ryon Panel found that the incident report system was flawed, all of those, did I go over that with the Board of Trustees?

MR. MOSS: Would you finish that?

Q. And then as amplified by that question, all right, that, I have got several series of questions. He's going to another line.

MR. MOSS: Well, I'll do it later.

Q. Do you recall that testimony being given before the Chanda Panel?

A. Yes sir, I recall him saying that they thought the incidents occurred. And nobody's ever denied that. The question is, are you making a mountain out of a molehill? Were they blown all out of proportion? That's the question.

Q. Then did you appear before the Executive, excuse me, before the Board of Directors?

A. When?

Q. In October of 1989. October 19, 1989, after the Ryon Panel.

A. After the Ryon Panel, yes, I went before the Board of Directors to answer any, at my request, to answer any possible questions they might have.

Q. And did they at that time indicate to you that they agreed with the Medical Executive Committee that you were guilty of disruptive and unprofessional behavior?

A. October?

The receiver is ultrasensitive, you could make a tiny sound and it picks it up. If you see what I mean.

Q. But now you have already admitted that you had a loud voice and lost your temper; isn't that correct?

A. Yes, sir, that's true.

Q. So you're not talking about a situation where you're just a little tiny voice here in the wilderness, are you, sir?

A. Absolutely not. But what I's saying is the tone of voice I could use to you or Mr. Moss or anybody else, if I, might be perceived as somebody else as being loud and overbearing or something.

Q. Well, you certainly haven't been loud or overbearing in this courtroom, have you, sir?

A. I have tried very hard not to.

Q. In fact, you have acted very differently here than you have in the operating room on occasion?

A. No, sir, I don't think so. I'm sorry, you said on occasion?

Q. Yes, sir.

A. On occasion in the operating room, I have been loud. On occasion in the operating room you have to wake people up, to get them to move. They're just not with the program, they're not paying attention, wandering in the halls, talking on the telephone, and

you know, you have to do something to get their attention.

Q. Well, I believe in response to questions yesterday from Mr. Moss, you indicated that you wouldn't be here today if you treated the people that worked with you in the hospital with the same respect you treated this jury?

A. I don't think that's a global situation, I don't think. There were instances when I was loud to nurses, there were incidents when I said sarcastic things to nurses. I think that I offended people, some people. I don't think it was ever directed at the person, I think it was always directed when a patient was -- the only time it upset me is if somebody was doing something and the patient wasn't cared for.

Q. But you're also trying to do it in such a way because you learned that if you insult nurses, you won't have to work with them again?

A. No, I don't think so. I think, I don't think I tried to do that at all. I think I was trying to give good care to patients.

I believe you said that you thought that there was a recommendation from medical supervisors or nursing supervisors that they document or write up Dr. Bryan.

A. Uh-huh.

Q. Is that a yes?
A. Yes. Yes, I'm sorry.

Q. And would you tell the jury why -- First of all, how do you know that and what do you mean by it?
A. It was recommended or it was suggested that in all incidences that required a conflict, that they would be documented. And it was strongly recommended that they do it that day.

Q. All right. When did that occur in relation to Dr. Bryan's suspension?
A. Oh, I have no idea when. You mean when it was suggested?

Q. Was it the year before or within a short time before his troubles, if you will?
A. Yes. I would say probably -- When I was aware of it, when I had heard it had been stated was about a year before. A year before the suspension.

Q. Were you aware of physicians other than surgeons that were, quote, out to get Dr. Bryan?
A. Physicians other than surgeons? No.

Q. Okay. Specifically, were you aware that Dr.

Bryan was in disfavor with either anesthesia or with Dr. Mills?

A. I don't know about Dr. Mills. I know that there were some anesthesia people who were not on his hit list or favorite list of the month.

Q. Okay. Were you made aware as to whether there existed any desire to get rid of Dr. Bryan by any people, that is, get rid of him from the staff?

A. Who would say this? Anybody?

Q. Anybody.

A. As I mentioned to Mr. Kay, it was an opinion that I formed from miscellaneous information. Now, whether it was spoken to me or I overheard it, it's very difficult for me to pinpoint, and that's why I hesitate to say. But yes, my opinion was that there were certain members on staff who would prefer that Dr. Bryan not be on staff.

Q. And this opinion was formed from conversations that you overheard or conversations that you engaged with nurses and other doctors.

A. Yes.

Q. Over a period of years?
A. Of years.

Q. Do you know why?
A. Why they would -- No. Anything that I say would be my own opinion.

MR. KAY: Object to the form.

BY MR. METZGER:

Q. Doctor, you were asked questions by various members of the panel, and I'm looking specifically at page 244, where Dr. Chanda asked you a question where he asked you, quoting: "Let me ask you one quick question. At the outset I believe you either offered the information spontaneously or in response to a question you thought there was either an effort or a conspiracy to get Dr. Bryan off the staff," and you said yes. Was that a correct answer?

MR. KAY: Object to the form of the question.

THE WITNESS: Yes.

MR. KAY: No proper foundation.

BY MR. METZGER:

Q. What did you mean by that, sir?

A. Well, I actually answered it earlier. I'm assuming that because there was a hearing that the hearing was directed toward moving in a way to get him off the staff. I thought that the reason we were all there, in fact, was to come to some kind of decision about removing him from the staff. I thought it was pretty obvious.

Q. All right, sir. Now, at page 246 -- and I just wanted to ask you about your answer at page 246 -- where you said: "Yes. Without mentioning names through two days or

that frequency?

A. Uh-huh.

Q. By multiple physicians?

A. By more than one.

DR. CHANDA: Okay.

MR. MOSS: Are you implying that someone is trying to get Dr. Bryan thrown off the staff?

THE WITNESS: Yes.

BY DR. HALLSTRAND:

Q. Libby, how many doctors would you say total?

A. That are what?

Q. That you feel fall into the category Dr. Chanda just asked you about?

A. Three.

Q. Okay. And what is the total number of physicians that you think interact in the operating room who might have an opinion?

A. Who might have an opinion regarding --

Q. Well, in other words, people who would be around who, if exposed to those comments of Dr. Bryan's behavior, good or bad?

A. Extensive, uh-huh.

Q. Are we talking, you know, in hundreds or twenties or, you know, how many doctors do you think that

on Dr. Bryan?

A. No.

Q. Do you know of any instance where administration has asked you to fill out an incident report on any physician?

A. No.

Q. Do you know of any instance where administration has asked other nurses to fill out incident reports on other physicians?

A. No.

Q. Therefore, do you know of any instances where administration has asked you or other nurses to fill out incident reports against Dr. Bryan?

A. No.

Q. Have any of your superiors among the nursing staff instructed you to fill out any incident reports against other physicians?

A. No.

Q. Do you know if any superiors on the nursing staff have instructed other nurses to fill out incident reports under physicians?

A. Yes.

Q. All right. Do you know of instances where those members of nurse administration have directed nurses to fill out incident reports on Dr. Bryan?

A. Instructed the staff to do so?

Q. Yes.
A. I wouldn't say instructed. I would say recommended.

Q. Do you know of any instance where the nursing administration has instructed nurses to prepare incident reports on other physicians?
A. No.

Q. Do you know of other -- of any instances where the nursing administration has instructed nurses to -- or recommended nurses, excuse me, to prepare incident reports on other physicians?
A. Yes.

Q. All right. So is it your testimony then that the nurse administration has recommended that nurses in the past fill out incident reports on several different physicians at Holmes, including Dr. Bryan?

A. Not several, no.

Q. How many?
A. Two.

Q. All right. Who are those?
A. Dr. Paine and Dr. Bryan.

Q. Okay. To your knowledge, have the nurses prepared those incident reports on --
A. Yes.

out the incident and document it.

Q. Did --

A. Now, you must remember, I am not an incident report person. I make out probably the least amount. There are some people whose personalities encourage them to make out incident reports over everything so you have to weigh who it is doing it. You understand what I'm saying?

Q. Yes, ma'am.

A. Okay.

Q. Have you prepared incident reports in the past?

A. Yes, uh-huh.

Q. Is that based upon what you believe is right or based upon the recommendation of your nursing supervisor?

A. Well, it's based on, one, what is required of the hospital policy; and then two, if it happened to me as an individual.

Q. Okay. Now, you talked about a situation where you were aware that a nursing administrative person had made a recommendation to a nurse to prepare an incident report regarding Dr. Bryan.

A. To document it, right.

Q. How many times do you know that happened?

A. I only know of one.

Q. Okay. And who was that nurse administrator?

A. I knew it. I knew you were going to ask me.

that to him? And he said for the heck of it. He touched me too, I can sue him.

Is that the truth?

A. That's the truth.

Q. And have you ever been encouraged or do you know that there's people on the staff that encourage people to write up Dr. Bryan?

A. Um-hum.

Q. Has that been going on for about three years?

A. Um-hum.

Q. Is Dr. Bryan treated differently than other surgeons?

A. Yeah, I would say.

Q. How?

A. Well, he's written up more. I heard a statement made by a particular anesthesia doctor that if -- which I'd rather not, you know, say his name, but I was told that, you know, if Dr. Bryan does anything, no matter what it is, you write him up 'cuz we got to get him out of here.

Q. Do you have an opinion about the suspension of Dr. Bryan and what's been going on?

A. Well, yeah, of course I do. I think that --

MR. STORMS: Mr. Lovering, I would object to any opinions that might be rendered by the witness. I think that that's the

out of the ordinary occurred, either to a patient or to a staff person.

Q. Okay. Now back at the beginning I asked you about whether Dr Bryan had been singled out or treated differently. Are you aware of any different treatment with Dr. Bryan concerning incident reports?

A. Am I personally aware of it? No, I'm not.

Q. Okay. Have you heard of instances within the operating room which evidence that he was being treated differently from other people?

MR. KAY: Object to the form of the question.

BY MR. MOSS:

Q. Let me withdraw it and ask it this way. Have you seen instances where Dr. Bryan has been written up where other physicians who have done the same thing wouldn't have been written up?

A. Yes, I have.

Q. Tell the jury about that, please, ma'am.

A. Incidence reports are a very personal type thing. If it's a physician that you are friendly with, that you have good rapport with, you will go that extra mile. If it's a physician in which you have strained terms, you are, as human beings, more tempted to write up that situation.

Q. Okay. As it relates to your own personal

experience --

MR. KAY: Let me just if I may, excuse me.

MR. MOSS: Sure, go ahead.

MR. KAY: Just move to strike that last answer as nonresponsive. Thank you.

BY MR. MOSS:

Q. As it relates to your personal experience, Ms. Ayers, would you characterize Dr. Bryan as being a disruptive person in the operating room? And you've been there.

A. No.

Q. Does Dr. Bryan have a temper?

A. Yes, he does.

Q. Do other physicians currently on the medical staff have a temper?

A. Yes, they do.

Q. Can you characterize Dr. Bryan's temper or aggressive behavior, whatever you'd like to call it, in relation to the other surgeons with whom you work?

A. I would say probably one-third of the surgeons or maybe a little less, have the same temperament as Dr. Bryan.

Q. So a little less than one-third of all the doctors that perform surgery at Holmes have some sort of

temper?

A. Yes.

Q. Has Dr. Bryan' temper or temperament changed in the period of time that you've been working with him?

A. Yes, it has.

Q. How has it changed?
A. He's become more mellow.

Q. Okay. When did that change occur?
A. Oh, I don't know. Several years ago.

Q. Okay. Are you aware that Dr. Bryan has been permanently suspended from staff privileges at Holmes Regional Medical Center?
A. Yes, I am.

Q. Did you testify at some of the hearings that occurred earlier?
A. Yes, I did.

Q. I gave you a copy of the transcript of the testimony. Have you reviewed that part today?
A. Yes, I have.

Q. As I understand it, you have quite a feeling of loyalty or a warm feeling in your heart for Holmes Regional Medical Center.
A. Yes, I do.

MR. KAY: Object to the form of the question.

Of those doctors who presently practice general surgery at Holmes Regional Medical Center, where is Dr. Bryan when you last worked with him, which I guess would be in 1990, '91 -- '90 -- where is he on the behavior scale, the temper scale, if you will?

MR. KAY: Object to the form of the question.

THE WITNESS: As what, one to ten or --

BY MR. MOSS:

Q. However you like to do it.

A. Well, temper is a subjective type thing. Every day Dr. Bryan didn't come in showing his temper and every day he didn't come in showing -- telling jokes and laughing. It would -- The times that I have seen him exhibit temperament has been directly associated with an incident that was ongoing.

Q. And would it be where something was not working properly or going smoothly about an operation?

A. Exactly.

Q. All right. Now, my question had to do with Dr. Bryan in the constellation of surgeons there, where would he fit within the picture? Was he worse than any of them?

A. No.

MR. KAY: Objection. Excuse me. Go ahead. It's the same objection I had

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?

A. Uh-huh.

Q. That's a yes?.

A. Yes, yes, I'm sorry. Yes.

Q. And the same one that yelled at you?

A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.
Q. Did they ever lose their staff privileges?
A. No.
Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are the powerful politically?
A. Yes.
MR. KAY: Objection.

BY MR. MOSS:

A. I can't speak for them.

Q. Well, have you had occasion to observe people who when working with Dr. Bryan became so tense that they actually broke out in tears?

A. Not when I've been in the room, no.

Q. Have you heard about that?

A. I can't think of any one particular incident. No, I can't think of anyone that comes to mind who's broken down in tears. I've broken down in another doctor's room, though --

Q. Isn't it true, Becky, in the OR suite that a lot of gals up there say I can take him for a couple of days but give me a break? I'm talking about Dr. Bryan. Give me a break and assign me someone else? Isn't that the case?

A. Yeah, but he's not the only one, though, Mr. Storms. Okay? We all need a break -- After you've worked with somebody for many, many days, you got to have a break.

Q. You're saying that he's not different than anyone else? Is that what you're saying?

A. No, he's not.

Q. He doesn't have a reputation in this hospital for being difficult to work with, being disruptive?

A. I don't think being difficult to work with, no.

Q. Doesn't have that reputation?

A. And he's not disruptive. I don't think he

does. Not any more so than any other doctors, though. He's not any different.

Q. How about -- Strike that.

MR. STORMS: That's all. Thank you, ma'am.

HEARING OFFICER LOVERING: Any questions?

(No response.)

HEARING OFFICER LOVERING: Then this witness may be excused. Thank you.

(Whereupon the witness was excused.)

(Whereupon a recess was taken.)

SANDRA MILLER,

the witness herein, after being duly sworn, did testify upon her oath as follows:

MR. MOSS: I will say this, and this is an apology to Mrs. Miller, that she's going to testify essentially to the fact that he's been singled out which has been testified to, that people have encouraged her to file incident reports against him; that his temperament has gotten better; and about the slapping or hitting not being unusual and that he's a good doctor. And I think I've characterized what you're going to say.

hands if you're in the way?

A. Yes.

Q. Have you been struck with, or tapped with instruments when your hand's in the way and the doctor's looking for some particular area?

A. I have had it moved with instrument before.

Q. Can you characterize Dr. Bryan as it relates to the total spectrum of surgeons that operate with you at Holmes Regional Medical Center or that did back in 1990, as it relates to his temper or his aggressive behavior?

A. They're all different temperaments. Some are very laid back and some have temperaments and ranking the ones with those that have temperaments, I would have to say he was fairly equal.

Q. Equal; Was he the worst man in the operating room?

A. No.

MR. MOSS: Thank you, that's all I have.

CROSS EXAMINATION

BY MR. SCHIRTZER:

Q. Good afternoon, Miss La Pointe. My name is Ron Schirtzer and I'm counsel for Holmes Regional Medical Center. And each of the individual doctors have been sued by Dr. Bryan in this case. I'm going to point

A. We were doing an aneurysm and I went in and automatically cathed the male patient, which was something that he never wanted the nurses to do. That was something he always wanted to do.

Q. And did he let you know that he was displeased?
A. Yes, he did.

Q. And did you have a conversation with him about that?

A. Yes, we did. We had a conversation afterwards and I apologized, I told him that I knew it was my fault, that I had messed up, that I would not do it again.

Q. Did he hold a grudge against you after that?

A. No.

Q. Did he continue to argue with you or anything after that one period of time?

A. I never had any problems with him after that.

Q. In other words, you'd made a mistake and it made him mad?

A. I had made the mistake, it was my fault, it made him angry. But we talked about it between ourselves, solved a problem, and I, you know, never had any trouble since.

Q. Have you ever refused to operate with him?

A. Never.

Q. When he got angry at you, did it make you so upset that you couldn't continue to function?

A. No.

Q. What type of surgery does Dr. Bryan do?

A. Dr. Bryan was a general surgeon, also a cardiovascular surgeon.

Q. Can you tell the jury about cardiovascular surgery?

A. Cardiovascular surgery is similar or is like when a patient had an aneurysm in the main blood vessel, going from the heart to the rest of the body, will rupture, bleed, or they can also have to have vein grafts in their legs due to their veins clotting off. Very tense surgery, especially when you're doing the big abdominal cases with the main aorta, it can be very tense, very hot moments in there. Everybody loses their temper.

Q. Do you get excited and nervous and stressed out in these operations?

A. Yes.

Q. Do doctors performing vascular surgery other than Dr. Bryan react when something goes wrong?

A. Yes, they do.

Q. How do they react?
A. A lot of them get angry. They're not in control

to have certain nurses in their rooms.

Q. Why does that happen? I thought everyone was supposed to get along in the operating rooms?

MR. SCHIRTZER: Objection, speculation.

THE COURT: Overruled.

Q. If she knows. You may answer.
A. Personalities.

Q. Now, as it relates to personalities, could you rate Dr. Bryan as it relates to his temper, as it relates to the other surgeons back in 1990?
A. I don't really understand how you mean.

Q. All right. Are there some surgeons that absolutely never have, never get angry?
A. Yeah, there are a few that never get angry.

Q. And is that a great statistical part, a great percentage of the surgeons, or a small percentage?
A. I'd say that's a small percentage.

Q. Would it be fair to say then that the majority of surgeons have some temper?
A. Yes, they do.
Q. Of those surgeons that have a temper, how would you rate Dr. Bryan? Is he the worst one there?
A. No, I don't think so. I think most of them are pretty much even quo.
Q. Even those that continue to practice at Holmes

Q. In your presence, has he ever become angry or mean, violent?

A. No.

Q. As it relates to surgeons, how many different surgeons do you think you have worked with?

A. Different types of surgeons? Or different people?

Q. Different people.

A. Hundreds.

Q. And in the six years that you worked with Dr. Bryan, did you, were you able to form an opinion about him as it relates to how he treated the nurses as compared to the other surgeons?

A. Yes.

Q. And would you tell the jury, please, ma'am, what your opinion of Dr. Bryan is as it relates to his ability to work with the people at Holmes Regional Medical Center.

A. I found him no different than any of the other surgeons that I worked with in the past. And I worked at several different hospitals in different parts of the country. If you knew what you were doing and were competent in your job, I felt like he had no problems with you. As any other surgeon would.

Q. Was he pleasant to you, polite?

A. Yes, always.

Q. And has he treated you with respect?
A Yes.

Q. Have you been with him in times when something has gone wrong with an operation, a bleeding or untoward event happen?
A. Yes.

Q. Does he become more excited?
A. I would say the -- yes, I'll say yes, he becomes more excited.

Q. And is that traditional or is that usual with other surgeons when things start going south, I guess is the expression?
A. Definitely.

Q. In those situations -- I have been south all my life ---- anyway. When things are not going well, has that been true with other surgeons?
A. That they become excitable?

Q. Yes.
A. Yes.

Q. Do tensions rise?
A. Exactly.

Q And when that happens with Dr. Bryan, have you seen him ever hit, scream, yell, stomp or do anything unprofessional?

A. No.

Q. Do you have an opinion based on your experience and being in the operating room as to whether he renders satisfactory and good medical care to the patients with which he was exposed?

A. Yes, I think he's an excellent surgeon. I think that he cares about his patients and that he wants the best for his patients. If something is going wrong or going south, he, I have never heard him -- he has never personally attacked me. If the patient's in trouble, he just wants the best for the patient. He wants everybody to act as a team and he is just very compassionate I think.

Q. And as far as your firsthand recollection, not what others might have said or hearsay or anything like that, have you had any problems with Dr. Bryan throughout your entire career before he left?

A. No.

Q. Let me ask you to assume hypothetically that he's been charged with being a disruptive influence at the hospital. Assume that for me. That he was disruptive and that's why he was let go. And in the two years and some months since Dr. Bryan has left the hospital, have you noticed any change in the way the smooth operation of the hospital is going?

A. No.

Q. Things haven't gotten a lot better? Are the nurses skipping and singing in the halls now?

A. No. I don't notice any change in the atmosphere.

MR. MOSS: Thank you, your witness.

CROSS-EXAMINATION

BY MR. SCHIRTZER:

Q. Good afternoon, Miss Fabian. What area of the, what area of surgery do you primarily work in at this point?
A. Orthopedics.

Q. And you have been doing that since 19 -- how long have you been doing that?
A. '88, '89. I don't remember.

Q. And from 1984 to 1985, you worked on I believe the open-heart unit?
A. Yes.

Q. And is that pretty much an exclusive assignment in terms of dealing mostly with open-heart surgeries?
A. When we started the program, we didn't have as many cases as they do now, so it wasn't as exclusive as it is now. We did do other cases.

Q. In a week, how many other cases would you do?
A. Maybe four.

Q. Have you ever struck a nurse with a metal tonsil tip?

A. I know I've brushed nurses' hands away, and by brushed, that's a very generous term. I know I slap nurses hands away when they're about to undo what I had taken an hour to do. And once again what I was doing was not life or limb threatening. I suspect if it was limb or life threatening, I may be more aggressive if I thought it would save the day.

MR. KAY: Just a moment, please. I have no further questions.

REDIRECT EXAMINATION
BY MR. METZGER:

Q. Just a few. Surgeons turned you down for this dying lady?

A. Yes.

Q. How did you feel?

A. Well, I mean it was a very desperate situation I don't have the expertise, and I didn't have the expertise that Dr. Bryan had at that time or any of the general surgeons. I could probably muddle through it and end up doing some damage, but it was a very desperate feeling, you know.

Q. And how long was Dr. Bryan with you trying to save the lady?

BY MR. FARRELL:

Q. Dr. Levitt, is what has been marked as Exhibit Number 2 for identification one of the incident reports that you referred to as having seen today for the first time?

A. Yes, sir.

Q. And did you formulate an opinion based upon your review of that incident report?

A. I think I would have called the doctor and asked him what went on. I would have found out what the other side of this issue was. Because I, this is the only one of the four that I wouldn't have thrown in the waste basket. But I didn't have the opportunity to do that.

Q. If you were to assume the allegations contained therein by the nurse that Dr. Bryan did, in fact, slap the nurse's hand, do you have an opinion as to whether or not that would be appropriate within the standard of care of rendering services in an operating room?

A. Yes, sometimes it's necessary if there's something that the nurse is going to do, misstep and you're not sure that a verbal command is going to do it, you have to push her away.

Q. And do you have any facts, have you relied

the name of the patient that can happen to anybody. That can happen to me tomorrow in a busy day at the office. The actual procedures weren't performed on a patient and they're so infrequent as to not even -- the doctor himself has enough sense to know that he made a mistake and try to do something about not doing something like that again. And he had some help from the nurses on the floor ln one case.

And this third thing about pushing the nurse's hand out of the way with a sucker, I've done that. In neurosurgery very often what we have to do is move our whole body and get the assistant out of the way in a hurry. I've explained to them afterwards, this is just how you have to do it when you want to get a quick change of view of the field. And this was with a patient who was deathly ill. I mean, this was in the middle of an emergency and he pushed the guy's hand with a tonsil suction, I mean, big deal. That isn't even worthy of an incident report. That's a laugher, that's a laugher, that's absurd.

Q. Do you have any other opinions in regard to that particular incident report?

A. No.

Q. When, approximately what time of the day

A. Yes, it did.
Q. In some cases did it hurt a little bit?
A. Yes, it did.

Q. Did you cry or quit or do anything?
A. I moved my hand.

Q. Okay. Why?
A. Because that was what he obviously wanted.

Q. Okay. And likewise, have you had a surgeon take your hand when you're a scrub nurse and move it away with his hand?
A. Yes, I have.

Q. Has that happened on more than one occasion?
A. Oh, yes.

Q. By doctors other than Dr. Bryan?
A. Oh, yes.

Q. Have any persons instructed you to write up any surgeon who touches you or moves your hand aside?
A. No, they haven't.

Q. Let's back off now and ask you if you're aware of a way of complaining about the actions of doctors at Holmes Regional. Do you know what an incident report is?
A. Yes, I do.

Q. Would you tell the jury what your understanding of an incident report is.
A. An incident report is to be used if something

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?
A. Uh, huh.

Q. That's a yes?
A. Yes, yes, I'm sorry. Yes.

Q. And the same one that had yelled at you?
A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.

Q. Did they ever lose their staff privileges?
A. No.

Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are they powerful politically?
A. Yes.

MR. KAY: Objection.
BY MR. MOSS:

cardiac arrest, the patients can bleed to death from it. And you're particularly concerned about this in a patient with coronary artery disease. So that's a relatively urgent problem, false aneurysm in the groin, particularly if it's enlarging fairly quickly, which is my understanding was the case here.

Q. All right, sir. Dr. Blackshear, based upon your review of what is called the Tina Stark incident report, what you have there in front of you, involving the aneurysm, that is, you have described it, do you have an opinion based upon your experience and training as a vascular surgeon whether or not this pushing away or this contact, this physical contact of the hand of Tina Stark by Dr. Floyd Bryan during that aneurysm procedure, whether that was an improper procedure by Dr. Floyd Bryan?

A. Yes, I do.

Q. What is your opinion?

A. My opinion is that it was not.

Q. Can you explain that?

A. Well, I didn't see anything in the description of what was going on here, either in the incident report, and I can't remember if I mentioned earlier, but I also reviewed some of Dr. Bryan's responses to these reports initially also. I can't see anything in

them that really relates to anything out of the ordinary. One, vascular surgery is a specialty which is somewhat stressful. Bad things can happen quickly. A very smooth operation can, over the course of a few seconds, deteriorate into a disaster if one loses control of a major blood vessel. The hemorrhage that can occur from a major blood vessel in a very, very short period of time is massive and it may threaten the life of the patient or certainly may increase the need for blood transfusions, and I think we're all aware of the problems associated with blood transfusions these days. So certainly maintaining control of the blood vessel, particularly a major blood vessel with a false aneurysm, which may under circumstance being [sic] infected because it has occurred through contact from the skin, is a very, very important and very significant thing. And if a piece of equipment is not functioning properly or if, if it's not set up properly or not being handed properly, the surgeon's obligation is to get it, period. Because there is really only one priority there and that's to stop the hemorrhage. If the patient's bleeding, that can't be tolerated.

Q. Dr. Blackshear, based upon that, which in your opinion is more important, the welfare of the patient

or any hurt feelings of a tech or a nurse?

A. Well, there is only one priority in the operating room and that's the welfare of the patient that's on the operating table.

Q. Now I want you to assume, sir, when you referred to Dr. Bryan's replies during the Dr. Chanda Panel and you referred to that, I want you to assume that Dr. Bryan, and this is a matter of record, testified before the Dr. Chanda Panel that he brushed Tina Stark's hand away during that aneurysm operation. Is that an improper act on his part under the circumstances of that aneurysm operation?

A. I don't think so.

Q. Did you see anything about the Tine Stark incident, that is, the aneurysm patient as you have described, which would just justify, based upon your experience and your training and your background of many years, which would justify Dr. Floyd Bryan being suspended of his medical staff privileges by Holmes Regional Medical Center?

A. Absolutely not.

Q. Why not.

A. Well, the incident is almost trivial in my estimation. And certainly whatever happens in the operating room, one has to keep in mind that the

A. Well, I don't believe that there was, the least bit unusual about this incident. I would not confine it to vascular surgeons. I think any surgeon often uses that maneuver of, either using their hands or whatever instrument they happen to be holding, to hit a retractor, and the message is, pull hard, pull further, it's a commonly understood method of communication in the operating room. And it's particularly useful whenever you're trying to do six things at one, which is the case in an operation like this. This was a gunshot wound to the upper abdominal aorta, the biggest blood vessel in the body and one of the spots in the body at which it is most difficult to see. It's exceedingly difficult to get exposure in that area under the best of circumstances, and when you have a huge hole in the blood, in the artery and the blood is powering out from everywhere, it's often almost completely impossible. So this sort of maneuver would be a routine maneuver during this procedure. One that i myself use many times, I have had used on me nay times and probably will have used on me any times in the future.

Q. Doctor, was this a life-threatening situation?

A. Absolutely. Obviously, the patient died.

Q. And when you have a life-threatening situation,

Has it been your experience and training that sometimes you have to do things abruptly and quickly?

A. Yes.

Q. Why?

A. Well, simply because you don't have time to discuss an action with a person that you might like them to engage in. Obviously it would be nice if everybody had the time to sit and explain the whys and wherefors of everything. But whenever you are working in an emergency situation like this, that simply is not available to you. You have got to do whatever is necessary, as quickly as is necessary and you can't stop what you're doing and take time to talk to another individual or request that they do this. In fact, you may be talking to somebody about something else at that point in time, and hit a retractor and if the hand's in the way, the hand gets hit and nobody usually thinks much about it. Kind of allows you to be a little more efficient. You're doing two things at once.

Q. All right, doctor, now this is the last instrument [sic] report. My question to you, sir, based upon your review of it and based upon what you have already told us in your opinion, first of all, do you have an opinion as to whether or not that physical

contact by Dr. Bryan under these circumstances involving Mike Greene, whether that was sufficient to warrant a complete suspension of Dr. Bryan's surgical privileges at Holmes Regional Medical Center?

A. Yes, I do.

Q. What is your opinion?

A. My opinion is that it wasn't.

Q. And would you please explain briefly why you are of that opinion?

A. Well, I don't know what else to say other than what I said earlier, in that this is a routine maneuver in the operating room, one that I use constantly, most of the other surgeons that I know use it constantly. And certainly if anybody's hand is in the way whenever you're hitting a retractor, it's unfortunate, but I don't know of anyone who has any malice in that action, they simply are trying to achieve a goal. That is, to do the operation as quickly and as efficiently as possible. If there is malice in it, the it's, obviously it's a different situation. But I saw nothing anywhere in the incident report or any comments about it that indicated that that was the case here.

Q. Doctor, incidentally, have you ever been asked to give a lecture at Holmes Regional Medical Center?

correct the stop cock while he was trying to get the stop cock and do it all himself. And without expressing this verbally, he just grabbed it, hit her hand, knocked her away, took it so that he could maintain control since he felt like it was up to him now to do it. And that's what precipitated the thing --

Q. All right, sir.

A. -- the whole situation.

Q In your time in the operating room, have you become familiar with the term of non-verbal communication?

A. Well, maybe not from being in the operating room, but just from general experience.

Q. All right, sir. Is it unusual to push people's hands aside or tap them or hit them?

A. I don't think so. I think there are different personalities and I think some people like to plan things out in their mind, go through things very carefully. Like in an operation you may be thinking several steps ahead. Other people like to talk a lot and to communicate. And when something suddenly happens, it's hard to just formulate a description and say get it done quickly, it's easier to just grab or put your hand. Or if a child is going to the stove,

it's a lot easier to grab his hand or slap it away rather than to give an explanation of why you shouldn't be doing that or think of something to say. I know instinctively you just reach out an do something when it has to be done quick.

Q. And likewise, the incident involving the gunshot victim who was bleeding, did you read that?

A. Yes, I did.

Q. In your opinion, were any actions of Dr. Bryan during that striking the hand of an operating room technician with a suction device unprofessional?

A. I really, I didn't think so. I thought that from my knowledge of what goes on in the operating room, something like that wasn't so unusual.

Q. In totality, if you add, instead of taking each one separately, if you say that all four of these occurred in a period of a month and a half, do they indicate that Dr. Bryan is losing it, that the is a danger to patients?

A. I don't think so. There was an incident where I think it was in that second case where there was so much bleeding going on where Dr. Bryan needed something, the nurse was on the telephone. He wanted something from the nurse that was on the telephone and I think what happened was she was involved in this

A. Yes.

Q. Without asking your permission?

A. Yes.

Q. Have you ever had him hit you with his hip to get you out of the way when you're standing there?

A. I wouldn't say hit. I would say nudged.

Q. Nudge. Without saying Miss Fabian, would you be kind enough to step to your left two paces or anything?
A. They usually don't take the time to say that.

Q. Have you ever had a surgeon in the midst of an operation with blood squirting out move your hand rather quickly without again asking your kind permission?
A. Yes.

Q. Does that go on every day at the Holmes Regional Medical center?
A. I would say to some degree, yes.

Q. And you said that you would find it to be a personal attack or something if someone slapped you or -- do you consider it a personal attack if a doctor nudges your hand, grabs your hand, moves it aside, taps you with an instrument?
A. No.

Q. Have you had doctors speak harshly to you, Miss

Q. Are these the very self same incident reports which were referred to in the Dr. Chanda Panel at the last evening?

A. Yes, they are.

Q. All right. Now, sir, based upon your experience and your review of the materials that you've described, have you arrived at an opinion as to whether any reasonable physician, acting as a member of the Medical Executive Committee at Holmes Regional Medical Center, could have reached the conclusion that the four incident reports, which we have referred to, together with the prior incident reports, were serious or significant enough to recommend that Dr. Bryan lose his privileges?

A. Absolutely not.

Q. Why?

A. First of all, an incident report is somewhat of an accident report to a degree indicating an unfortunate or accidental circumstance that takes place in the care of a patient, which could be detrimental to patient care and needs to be documented. Somebody slips and falls in the hospital, falls off a stretcher, falls off an x-ray table, and it's usually something significant and something relating to patient care.

Q. A what?

A. A cannon ball go through half of her body.

MR. KAY: Your Honor, we have to strike. This again doesn't go to the four incidents and the subject of testimony.

THE COURT: Sustained.

BY MR. METZGER:

Q. Dr. Guy, based upon your review of those four incident reports, do you have an opinion, taking every word that you read in those four incidents as being absolutely true, do you have an opinion as to whether they formed, either singularly or together, a basis for taking Dr. Bryan's privileges away permanently?

A. Absolutely not.

Q. And why not?

A. I don't think they're of enough gravity to warrant suspension from the staff. I think that type of punishment is far too severe.

Q. And then to move on, I'm almost through, considering that he did have some problems in the past and we're aware of some incident reports, I think as many as twenty three prior incident reports spanning ten years. Even taking those -- have you reviewed those?

A. No.

They looked into that, they found that stack really wasn't that big, that there were a lot of duplicates and then when they looked at what was left over, there were a lot of trivial things that they thought weren't significant. And that consequently, they discounted the argument that there was a big stack of complaints, that there really weren't a big stack of substantial complaints.

Q. Were you aware that Dr. Bryan was suspended in 1988?

A. I have learned of that subsequently. I don't think I was at the time.

Q. Dr. Ryon tell you that?

A. I don't think I knew that at the time.

Q. Are you aware of the fact that in 1989, Board of Directors of the Hospital told Dr. Bryan that he felt, that they felt he had acted in a disruptive and unprofessional way and that if he continued to act that way, he would lose his privileges?

A. No.

Q. Would that be significant to you if the Board of Directors of the Hospital issued such a warning?

A. I would take serious notice of that.

Q. Directing, going on further in that same third point, I believe there is a specific reference to that

permanently the privileges of Dr. Floyd Bryan.

Q. All right. Dr. Kucera, assume, and this is a matter of record, it's in evidence, the Dr. Chanda Panel recommended a suspension of two years, and further assume, it's a matter of record, the Medical Executive Committee then chose to permanently revoke Dr. Bryan's privileges. Do you have an opinion as to what basis, what reasonable basis, if any, they had in doing that?

A. Well, the Executive Committee has the option, they can affirm, modify or completely change the recommendation of that Hearing Panel. They are entitled and allowed by the By-laws to do that. But in the record I could find no reason why the two year suspension recommended by the Hearing Panel was turned into a permanent suspension with no opportunity to ever reapply. The reasons for that action are not given in the records I reviewed.

Q. Do you have an opinion as to whether the Defendants acting as members of the Medical Executive Committee acted fairly towards Dr. Bryan in revoking his privileges?

A. Well, that particular incident violated the rules of fairness and the American Medical Association Code of Ethics because in any Hearing Panel the

physician, the doctor who whose privileges are being investigated or denied or changed has the option, according to the rulings of fairness, to hear the testimony and to address it and give his reasoning for the actions that took place. In that particular instance, Dr. Bryan was not present, he was told, I think previously, that those issues would not be addressed, and then they were addressed in his absence without an opportunity to respond. And that is in violation of due process and that is in violation of the American Medical Association code of ethics.

Q. Now, sir, referring to the Medical Executive Committee Minutes of July 10, 1989, and let me get them for you, they've been marked into evidence, I've got my copy, but let he get the exhibit number. Referring to the Executive Medical Committee minutes of July 10, 1989.

All right, sir. I'm handing to you, or with the Court's permission handing to you the Executive Committee Minutes along with other minutes, but the ones I'm referring to and I'll ask you a question or two on are the minutes of July 10, 1989 of the Medical Executive Committee of Holmes Regional Medical Center. May I approach?

THE COURT: Yes, sir.

[TEXT OMITTED DUE TO
DEFENDANT'S OBJECTION AT TRIAL]

Q. do I understand correctly that the first time you saw the four incident reports was earlier today?

A. Yes, sir.

Q. In regards to the Chanda panel's review of those four incident reports do you have any opinion?

A. Yes, I do. If they concluded that this

guy was unfit to practice in the hospital on the basis of those four incident reports, there was something very wrong with that panel. I don't know what it was, but there was something very wrong with that panel.

Because I was known as a law and order president of the staff. If those four incident reports appeared on my desk, three of them I would have thrown into the waste basket immediately and the first one involving the hitting the nurse's hands I would have called the doctor and tried to clarify it. And to me just reading it it sounds like one possible excuse was that she was about to do something dangerous and he was afraid that just by doing it verbally that she would go ahead and do it anyway. And by physically interrupting her actions he was able to avert a catastrophe.

But because of the nature and sensitivity of the issue, I would have probably called the guy up and found out what was going on. Something, by the way, which the chief of staff of your hospital never did. He said he never saw those incident reports, Gurri did.

Q. Did you bring any records with you today?

Q. Were some Surgeons?

A. Yes.

Q. All right. Go ahead. I didn't mean to interrupt you.

A. I was in a very difficult position because clearly, this thing had reached a climax, and there are camps that were forming, and it had gone on with Floyd for years before I had gotten there, and as a new staff member, I was in an awful position because I thought I saw an injustice of the system. I make no pretense to know how it got there over a ten-year period or any of the circumstances around it, but I felt it was almost like a McCarthy-like hearing that was going on. I had no understanding of how it could go to that level, and because of that, I felt I should at least speak to that issue.

MR. KAY: Move to strike.

THE WITNESS: The other part about it was that there -- the camps were so well defined where people were either supporting what he did or not supporting what he did, and the ones who understood that I was going to be going to the hearing said exactly that. I don't know why you're doing that. You're going to really put yourself and your future in jeopardy. You're going to really possibly

A. Yes, he testified for a brief period of time.

Q. And after you arrived at a decision of two years, rather than what the executive committee had suggested, a permanent suspension, what happened next? Do you know? Did you follow this at all?

A. No, no, in fact, no, not at all

Q. Well, let me ask you to assume hypothetically that the executive committee following receiving the panel recommendations of two years, said no, we want a permanent suspension, overruled you. Assume that to be true.

A. Well, we assumed that would be true. Just I mean, we did assume that.

Q. And who was the chairman of the executive committee that overruled your decision?

A. Well, it would have either been Dr. Mills or Doctor, Dr. McClure, I presume, whoever's -- I don't know who it was.

Q. Well, let me ask you to assume it was still Dr. Mills. And then from there, Dr. Bryan's given a right to appear and he appeals to the board of trustees. Were you aware that that happened?

A. We knew from the bylaws that Dr. Bryan was, would be allowed an appeal at the board level if the executive committee, whatever the executive committee

had said.

Q. All right, sir. And do you know, sir, that Dr. Armstrong was also on the executive committee that brought the charges?

A. Yes, he was chief of surgery at the time.

Q. He testified in front of the panel?

A. Yeah, he did testify.

Q. He did, didn't he? Remember that?
A. Yeah, I though you --

Q. And then, he was on the executive committee that reversed your decision?
A. They did not reverse our decision.

Q. Well, they added lifetime to two years, didn't they?
A. Yeah, I wouldn't consider that a reversal of decision.

Q. Well, let's just say, did they change the punishment?
A. Yeah. Two years is a pretty stiff penalty. Yes, they changed or they had retained the same decision that they had made originally.

Q. Didn't look like anything you did changed their mind, did it?
A. No. I wouldn't think that it would have.

Q. Do you know, sir, that Dr. Armstrong is a member

HEARING OFFICER LOVERING (cont'd):

1989, and I announce on the record to counsel that you're informed of the notice of this hospital record.

With that, I am ready to announce the ruling insofar as the prior misconduct is concerned or the prior alleged misconduct. The committee is not going to receive evidence of misconduct or disruptive behavior or incidents of misconduct or disruptive behavior occurring prior to the hearing panel convened and chaired by Dr. Ryon. And that was in May of '89, I believe. Maybe you've got a better recollection of the date.

MR. MOSS: It was concluded in May of '89, I believe.

HEARING OFFICER LOVERING: All right. Any incidents prior to that time, the committee will not permit evidence, any evidence relating thereto. The committee is aware of the report of the Ryon hearing committee and doesn't agree or disagree with the merits but wants to state on the record that they are familiar with that report and draw no conclusions from it.

With that, Mr. Storms, if you're ready

to proceed, sir.

MR. STORMS (attorney for the hospital): Yes, sir. Mr. Lovering, am I to understand that the ruling of the hearing officer is that the records of the hospital relating to Dr. Bryan will not be admitted?

HEARING OFFICER LOVERING: You are correct if you are saying that the prior incident reports involving misconduct or unprofessional behavior prior to the final report of the Ryon hearing committee in May of 1989 is not going to be received in evidence.

MR. STORMS (attorney for the hospital): All right. So may I call the attention to the hearing officer of the provision in the bylaws which is 43.8, which talks about basis for decision. "The decision of the hearing panel should be based on the evidence produced at the hearing. The evidence may contain the following: Any material containing the hospital files regarding the person who requested the hearing so long as this material has been admitted into evidence and that copies have been provided to the person involved." And

so I understand that it is the ruling of the chair that with respect to those records, only those records that had occurred subsequent to Dr. Ryon's panel will be admitted; is that correct?

HEARING OFFICER LOVERING: That's correct. And that would have to relate to the incidents that are set forth in the letter to Dr. Bryan of March 9th and May 16th, two on the 16th of May and one on March 9th, I believe. Correct me if my dates are wrong.

MR. STORMS (attorney for the hospital): I think it's the 7th and the 16th.

HEARING OFFICER LOVERING: All right. The 7th and the 16th.

MR. STORMS (attorney for the hospital): All right. We would go ahead and call Nancy Runge as our first witness. Let me go get her.
WHEREUPON:

NANCY RUNGE,
a witness herein, having been duly sworn, did testify upon her oath as follows:

DIRECT EXAMINATION
BY MR. STORMS:

MR. STORMS (attorney for the hospital) (cont'd):

the Health Care Quality Improvement Act. I am informed by Mr. Geary at this time that apparently you were unable to get in touch with Mr. Metzger to confirm that stipulation; is that correct?

MR. GEARY: Correct, but I've also reviewed all the correspondence between yourselves and, as you know, everything that passed between us has been confirmed in writing. There is nothing confirming the stipulation that you're alleging.

MR. STORMS (attorney for the hospital): There's no question about it not being in writing. I spoke to counsel for Dr. Bryan here at the hearing the last time and we had that stipulation and I assume that as most attorneys he would honor his stipulation and I assume he will when you can ask him.

On another matter of housekeeping, I would proffer -- I recognize what the chair's ruling is with respect to prior incidents. I would just proffer these and ask they be marked as exhibits, that which is entitled "Miscellaneous Incident Reports" and that which is entitled "Action Taken, Conduct

Correspondence."

HEARING OFFICER LOVERING: Mr. Storms, certainly we'll mark that for identification. I think, you know, both sides --

MR. MOSS: Subject to your prior ruling, isn't it, Mr. Lovering?

HEARING OFFICER LOVERING: Yes. I think both sides ought to put whatever record they feel is adequate and we will not receive it in evidence but it will be marked as being proffered and marked for identification.

MR. MOSS: I might say for the record I've never seen those documents. They're very attractively bound and beautifully colored and I don't know what they are so I object to them.

MR. STORMS (attorney for the hospital): For the benefit of the record I would say that everything which is contained in those documents has been provided to counsel for Dr. Bryan in exactly two different versions, one initially and at the last hearing they wanted a copy in that particular version and copies were provided in that version, so I don't know whether Mr. Moss was provided with them but Mr. Geary

was.

MR. GEARY: I was provided with sanitized, excerpted minutes and when we got here August 7th we found a stack about that much bigger. (Indicating)

HEARING OFFICER LOVERING: Sure. Okay. We've already ruled on this. We will mark this pink volume "Action Taken, Conduct Correspondence" as Hospital's Exhibit 1 for Identification and this second volume which is pink also marked "Miscellaneous Incident Reports" as Hospital's Exhibit 2 for Identification only.

(Whereupon Hospital's Exhibit 1 and 2 were marked for Identification.)

MR. STORMS: We would like to call Dr. Mills as our next and last witness on behalf of the hospital.

BARRY A. MILLS, M.D.,
the witness herein, after being duly sworn, did testify upon his oath as follows:

DIRECT EXAMINATION

BY MR. STORMS:

Q. For the record, will you state your full name, please, sir?

DR. CHANDA: Okay.

HEARING OFFICER LOVERING: Thank you very much, Doctor.

THE WITNESS: Thanks. Thank you for the opportunity to speak.

(Whereupon the witness was excused.)

DR. CHANDA: Mr. Lovering, could I request a brief discussion with you in the absence of counsel?

HEARING OFFICER LOVERING: Yes. Would you please give us --

MR. MOSS: Are we supposed to go home?

DR. CHANDA: No, no.

HEARING OFFICER LOVERING: No, just give us a few moments.

(A discussion between Hearing Officer Lovering and the Hearing Panel was held off the record, outside the presence of counsel and parties.)

HEARING OFFICER LOVERING: This will be received as Dr. Bryan's Exhibit number 6 and it was previously marked Dr. Bryan's Exhibit 1 for Identification.

Other than that, I think the record of the evidence is all straight.

Gentlemen, the committee has elected to

receive into evidence as Committee's Exhibits B and C what was previously marked as Hospital's Exhibit 2 and -- 1 and 2 for Identification and these are the prior disciplinary records of Dr. Bryan that were proffered on behalf of the hospital.

MR. MOSS: What can I say? Of course, had it been done during the time I could have presented testimony. I could have presented testimony as I did in the first hearing about those reports but the committee having elected to receive them, I don't know what to say other than I felt this was a closed case. But be that as it may, I don't know what's an appropriate reaction at this hour other than I -- we had made our arguments to the hearing panel, the hearing panel has ruled. If the committee wants to see them, I don't know what I can do about them other than there they are.

HEARING OFFICER LOVERING: The committee would like to have them in evidence.

(Whereupon, Dr. Bryan's Exhibit 6 was received into evidence.)

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(Whereupon, Committee Exhibits A and B were received into evidence.)

A. No, but we never head the side of the people who had written the incident reports, we did not discuss those incident reports.

Q. Well, the incident reports are what? Just tell the jury, they haven't seen them yet. What goes into an incident report? When are they written? Who writes them?

A. Anybody at a hospital can write an incident report about anything. That's my understanding of how the system works. Whether it is a patient received the wrong medication, that's an incident. Anything that is above and beyond what is considered to be normal. And so, so anybody, if a patient slips on the floor, falls out of bed, if something is broken, a blood specimen is lost, an incident report could be written for anything that is considered to be over and above what is everyday, an everyday occurrence.

Q. What is the difference if the physician who is charged in an incident report doesn't ever hear about the incident report, between an incident report and say talking behind somebody's back?

A. I mean, I presume an incident report could be considered to be hearsay if somebody make a complaint that you're never given an opportunity to defend yourself. But that's not, I don't think that's

hearings.

Q. All right. And did you, sir, review at some point prior to voting review those incidents reports which are in front of you?

A. Yes, sir.

Q. Did the defendant in that case, the plaintiff in this case, Dr. Floyd Bryan, have an opportunity to present any evidence whatsoever concerning the truthfulness of those incident reports?

A. Not at our particular hearing, no.

Q. And did you, sir, in assuming that as to deriving the punishment to be imposed, reach some sort of conclusion in your mind concerning Dr. Bryan and whether he had been a disruptive physician over the years?

A. It was the impression of the panel and myself included that there was disruptive behavior.

Q. And what was that based on, sir?

A. Based on the combination of the incidents provided from previous incidents as well as the testimony at the hearing.

Q. Okay, sir. And do you recall, sir, seeing various evidence of the executive committee minutes that were introduced into evidence where the executive committee, for example, felt that the incident

panel that this was not an error on Dr. Bryan's part but it was a miscommunication.

Q. And as a result of his not appearing, did the records of the minutes in front of you reflect that the executive committee voted not to discuss the matter with Dr. Bryan?

A. Yes.

Q. And they went ahead and voted to suspend him for four weeks?

A. That's correct.

Q. And his side of the story wasn't heard until the panel; is that a fair statement?

A. Yes.

Q. Okay. Now, sir, at the hearing panel, do you recall that at some point during the hearing, it was introduced by representative of the hospital, a stack of incident reports that went back to, I believe it's as early as 1978. Let me hand you defendant's 1 and ask you, flip through those and see if they are incident reports that were discussed by your committee in part back in 1989.

MR. KAY: Sorry, did you say in part?

MR. MOSS: Yes, sir.

A. Well, there was a stack of incident reports. I can't tell you here now if this is the exact stack.

There were a number of incident reports, the panel really didn't spend much time on those because they were, we did not know ahead of time they were going to be at issue.

Q. All right, sir. Were they introduced to prove or to show that Dr. Bryan had a long history of disruptive behavior?

A. I would guess that they were.

Q. Now, did you hearing panel in its deliberations discuss whether these incident reports would serve as a basis for discovering that Dr. Floyd Bryan had a long history of abusive and disruptive behavior?

A. Ask that again.

Q. I'll ask it again. Those incident reports in front of you, there was charged, were they not, by Mr. Storms that the hearing panel, that Dr. Bryan wasn't really being tried or suspended for four weeks for these three matters that you read earlier, it was a culmination of his long and abusive history; is that a fair statement?

MR. KAY: Object to the form of the question. It's leading and also calls for hearsay.

THE COURT: Sustained.

Q. What was your understanding of the purpose of the hospital attorney introducing incident reports

into evidence which had nothing to do with the charges?

MR. KAY: Objection, calls for speculation on the part of this witness.

THE COURT: Overruled; he was part of the panel.

A. I think that, that the -- I don't think these incident reports had that much in there, Mr. Moss.

Q. Now I found the missing document. Let me hand you defendant's 93, which is a portion of the transcript of the executive committee minutes. Do you recognize that, sir, as being the basis upon which the graduated punishment was to be based?

A. Yes, I do.

Q. All right, sir. And would you publish to the jury what if anything the ad hoc committee or the executive committee of the, the executive committee had stated to Dr. Bryan concerning whether he would be advised of any incident reports.

A. Well, I think the inference is that, that he should have been notified.

Q. All right, would you read just that portion that discusses what they would do as it relates to Dr. Bryan.

A. The penalty?

the incident reports were reviewed, the following recommendations were made. Any further written complaints to be reviewed by the subcommittee and interpreted as either significant or insignificant. If felt to be significant, the committee will discuss the report, possibly review the employee involved as well as discuss with Dr. Bryan.

Q. Did that form any part in the conclusion of the committee concerning the discussion of incident reports with Dr. Bryan?

A. Well, the committee didn't feel that there was a discussion of incidents with Dr. Bryan.

Q. And specifically that big stack in front of you, what was the decision, if you will, of the Ryon committee, of which you were a part, concerning whether Dr. Bryan had had those incident reports discussed?

A. I think the assessment of the committee was that those incident reports were not discussed with Dr. Bryan. Not in toto.

Q. And let me direct your attention to a document which I will hand you, which is number 400 for the plaintiffs. A letter addressed to Mr. Means from Dr. Ryon. Would you take a second and -- have I shown you that before today?

EXECUTIVE COMMITTEE
May 29, 1990

A called meeting of the Executive Committee was held on Tuesday, May 29, 1990 at 6:00 P.M. in the Executive Board Room.

Those present were:

Barry A. Mills, M.D., Chairman
Joseph A. McClure, M.D.
Joseph A. Gurri, M.D.
Pablo Enriquez, M.D.
Raymond A. Armstrong, M.D.
Lyle Saltzman, M.D.
Terry Koubek, M.D.
Timothy Reid, M.D.
Angel Quinones, M.D.
Pio Sian, M.D.
Scott Gettings, M.D.
Alfred Tortorelli, D.D.S.
Ronald Levy, M.D.
Mahesh Soni, M.D.
Peter Koretsky, M.D.
Michael J. Foley, M.D.
Michael D. Means

The meeting was called to order at 6:05 P.M. The purpose of this called meeting was to review three incident reports on Physician #01033, one dated March 11, 1990 and two dated May 16, 1990. Dr. Mills read a letter to the Executive Committee from Dr. Armstrong (Chairman, Department of Surgery), Dr. Mills (President, Medical Staff) and Michael Means, (CEO) requesting an investigation of the two incidents which occurred on May 16, 1990. Physician #01033 was placed on administrative suspension on Friday, May 18, 1990 for a 30-day period pending an investigation by the Executive

Committee.

At a called meeting of the Executive Committee on April 9, 1990, it was the recommendation of the Committee that the clinical privileges of Physician #01033 be suspended for a two week period due to a review of an incident which occurred on March 7, 1990 involving the striking of a nurse in the OR. Physician #01033 has requested an appeal in light of this recommendation.

The first witness interviewed was Michael Green, RN, who described the incident as it happened on May 16, 1990 at approximately 10:30 PM in OR #6 as he was assisting Physician #01033 with an emergency gunshot wound patient. Mr. Green stated that Physician #01033 was already annoyed with ER because they had intubated and tried to resuscitate the victim without transferring him directly to the OR as he states he told them on the phone to do. Mr. Green had inserted a foley catheter and was attempting to retract and hold for Physician #01033 in the abdominal area where profuse bleeding was taking place. Instead of instructing Mr. Green to move his hands, Physician #01033 struck his hand with a metal instrument. Mr. Green advised that his hand was struck with such force that he

felt the pain for approximately 5-10 minutes afterwards, but rather than begin a verbal confrontation in an already extremely tense environment, he chose to be relieved in the OR by Ms. Frazier and write up the incident after leaving the OR. He stated that in his entire hospital career, he had never been struck in this manner and that he felt the behavior inappropriate and unprofessional and intends to bring legal action against the physician.

Bill Kaufmann, ORT was also interviewed regarding this incident and stated that he saw and heard Physician #01033 strike Mr. Green with the instrument, but does not remember whether Physician #01033 asked or inferred that he wanted Mr. Green to move his hands. He stressed the fact that the action was deliberate and forceful. He also explained the high level of stress involved in a trauma situation of this type, but also says that he has never seen a physician act this way even during trauma or other surgical procedures during his employment as an OR Tech.

Delores Frazier, R.N. was invited into the meeting. She stated that Physician #01033 asked her to call Dr. Armstrong and ask him to assist in this trauma case. When she reached Dr. Armstrong at home, he informed her that he was ill and could not come in. Ms. Frazier says that when she told Physician #01033 and asked if he wanted her to call someone else to assist, his answer was, "If Dr. Armstrong, Chief of Surgery, cannot be here, then I don't want you to call anyone else." She says that she relieved Michael Green shortly afterwards in the OR but was not in the room during the incident.

Physician #01033 was interviewed regarding this incident. He described the events that occurred on the evening of May 16, 1990 beginning with a phone call from the ER regarding the case coming in of a young, white male with a gunshot wound to the abdomen. He came to the ER and was distressed to find that the patient had not been taken to the OR as he had instructed on the phone initially. He graphically described the entire operation, but when questioned about the incident of his "hitting" Michael Green, he claims that he does not remember this happening. He claims that the first he heard of this was when he received a copy of the incident report. He suggested that if he felt the need for Michael to move his hands, he would have "tapped" him or asked him, to move his hands as so often had happened on other occasions and in his training program. He stated that he has written a letter to Mr. Green apologizing for the incident.

The other incident that occurred on May 16, 1990 involved a patient by the name of Sandra Capitani, a patient of Dr. Isaac Kalvaria's who had been admitted for treatment of pancreatitis. At 3:30 P.M.,

Physician #01033 called 7 West and requested that this patient be prepared for gall bladder surgery. Nancy Runger, R.N. attempted to get the patient to sign a surgery authorization and she refused. The nurse called surgery back to inform them of this and Physician #01033 requested that the patient be brought to the holding room where he could talk with her. The patient had agreed to this and while Ms. Runger was preparing the pre op check list, Dr. Kalvaria arrived and inquired as to why the patient was being prepared for surgery. He was informed that Physician #01033 had stated that gall bladder surgery was to be performed on this patient. Dr. Kalvaria then called Physician #01033, who realized this was not the patient he thought it was, called the OR desk and cancelled the surgery on the patient.

Nancy Runger, R.N. and Dr. Kalvaria were interviewed regarding this incident and stated the above occurred as reported. When questioned about this incident, Physician #01033 said that he thought the patient in question was another patient, with a similar but more complex problem, whom he had seen in his office as a consult several days prior. He assured the Committee that this patient could not have been put to sleep and operated on because he is always in the room with the patients before they are put to sleep and would have realized at that point that this was not the right patient. He claimed it was a case of mistaking one patient for another due to having seen both previously.

The final incident reviewed occurred on March 11, 1990 and involved a patient by the name of Mary Roberts. Judy Botkin,

Nursing Coordinator was present at the meeting and described the incident as follows: on the morning of March 11, 1990, Physician #01033 called SICU to request a bed for a patient needing a pre-op Swan Ganz and that the patient's name was Mary Roberts. The patient was located on 4 North and transferred to SICU in preparation for the procedure. The nursing staff in SICU found that Mrs. Roberts was unaware of any plans for surgery on Monday or plans to insert a Swan Ganz. Concurrently, Dr. Turse arrived on 4N to visit his patient, Mary Roberts and was advised that she had been transferred to SICU per order of Physician #01033. Dr. Turse went to SICU to speak with Physician #01033 and when it was determined this was indeed the wrong patient, Dr. Turse spoke to the patient and her family and Mrs. Roberts was moved back to 4N. Physician #01033 then called SICU and made arrangements for the correct patient to be transferred for the procedure. He then went to Mrs. Roberts room and apologized to her and her family for his mistake.

Physician #01033, when questioned abbout [sic] the above incident, stated that he had intended to call for a patient of Dr. Pocoski's named Mrs. Genheimer, who required a Swan Ganz. He asked for the wrong

patient and accepts responsibility for the incident as human error. Again, he assured the CoMmittee that he would have realized when he saw the patient that it was the wrong one.

Anita Lymhurner, R N., Vice President of Nursing was interviewed and stated that there are five major nursing concerns regarding the problems with Physician #01033. These are (1) staffing - there are nurses and techs that refuse to work with this physician and others that are hesitant to do so: (2) recruitment and retention - due to the tension and stress, including comments often made to new nursing staff, it is becoming increasingly difficult to keep nurses: (3) harm to the staff - verbal abuse, and now physical abuse, would tend to escalate as the problems continue: (4) "image" of the hospital and Medical staff - will be affected by continuing to allow this physician to create problems in the OR and on the floors: and (5) potential for unionization - in order to protect their rights, the nursing staff may be tempted to seek out a union.

After all this information had been discussed and reviewed, the Committee members heard comments from Dr. Gurri, Past President of the Medical Staff, Mike Means, CEO and Drs. Foley and Armstrong about the long-term problems with this physician, the numerous suspensions and interviews, as well as the mandate by the Board that his actions be closely watched for a 12-month period. It was the decision of the committee that due to the escalation of problems involving hospital staff and concern for patient welfare and safety, that a summary suspension of Physician #01033's clinical privileges become effective immediately. This suspension

would not allow Physician #01033 to admit patients, take ER call or take consults. He can, however, care for patients already in the hospital. A motion passed to recommend that Physician #01033's clinical privileges be permanently revoked, with no chance for reapplication.

There being no further business, the meeting adjourned at 9:30 P.M.

/S/ Barry A. Mills, M.D.
Barry A. Mills, M.D.
Chairman, Executive Committee

arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

44.4 Nature of Appellate Review:

44.4.1 The Chairman of the Board shall appoint a Board Review Panel composed of not less than three persons, either its own members, reputable persons outside the hospital, or a combination of the two, to consider the record upon which the recommendation before it was made. The Board Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Each party shall have the right to present a written statement in support of his position on appeal, and in its sole discretion, the Board Review Panel may allow each party or its representative to appear personally and make oral argument. The Board Review Panel shall recommend action to the Board.

44.4.2 Action by Joint Conference Committee:

In any case in which the Board Review Panel

number of the Dr. Chanda Panel Report, which is in evidence?

THE CLERK: Plaintiff's 401.

MR. METZGER: May I get it, Your Honor?

THE COURT: Sure.

MR. METZGER: May I approach the witness Your Honor?

BY MR. METZGER:
Q. Handing you, sir, 401 Exhibit in evidence before this Court and Jury. Would you kindly take a look at that, sir.

A. I have read this, yes.

Q. Now you did have the report, but according to your testimony, you did not have the transcripts or the exhibits; correct?
A. At the time of this report?

Q. At the time you made your final decision to ban Dr. Bryan from the hospital permanently.
A. We did not have a transcript at that time, no, sir.

Q. Nor did you have any exhibits?
A. Nor did we have any exhibits.

THE COURT: Mr. Sullivan, I think that Mr. Metzger is getting at, you had that report; you said you had a big pile of stuff, right, that you looked

DEPARTMENT OF PROFESSIONAL REGULATION

MAR 2 1992
PERSONAL AND CONFIDENTIAL

Floyd T. Bryan, M.D.
1402 Oak Street
Melbourne, Florida 32901-3113

Re: Case No. 91-01501

Dear Dr. Bryan:

Please be advised that the complaint referenced above, filed against you by the Department of Professional Regulation regarding allegations that you prepared a patient for gall bladder surgery who was not a candidate for surgery and struck the hands of an OR technician during surgery, has been investigated and the findings reviewed by the Probable Cause Panel of the Board of Medicine. Pursuant to Section 455.225(2), Florida Statutes, and Rule 21-031.001, Florida Administrative Code, the Department finds that there is insufficient evidence to support the prosecution of the allegation that a violation of Chapter 458, Florida Statutes, or the rules promulgated thereunder has occurred. Therefore, the case has been dismissed.

Thank you for your patience and cooperation during the investigation of this matter.

Sincerely,

/S/ Carlos J. Ramos
Carlos J. Ramos
Senior Attorney

CJR/dpb/tc
cc: Joseph Metzger, Esquire

10.2.11. to determine minimum continuing education requirements for appointees to the Staff.

10.2.12. In any instance where a member of the Executive Committee has a conflict of interest in any matter involving another appointee to the Staff or issue which comes before the Executive Committee or in any instance where a member of the Executive Committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter, and shall, at the request of a majority of the Executive Committee, absent himself from the meeting during that time although he may be asked and answer questions concerning the matter before leaving. The Chairman of the Executive Committee, his representative and such members of his Committee as he deems necessary shall be available to meet with the Board or its applicable Committee on all recommendations that the Executive Committee may make, it being the purpose of these Bylaws to increase direct communication between the Board and the Executive Committee on all matters within the scope of the Executive Committee's duties.

99th CONGRESS
2D SESSION

H.R. 5540

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 17, 1986

Mr. Wyden (for himself, Mr. Waxman, Mr. Madigan, and Mr. Tauke) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1.SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**--This Act may be cited as the "Health Care Quality Improvement Act of 1986."

LEGISLATIVE HISTORY
P.L. 99-660

Much of Title IV of this Public Law was derived from H.R. 5540. House Report (Energy and Commerce Committee) No. 99-903, Sept. 26, 1986 [to accompany H.R. 5540] is set out:

HOUSE REPORT NO. 99-903

[page 1]

The Committee on Energy and Commerce, to whom was referred the bill (H.B.5540) to encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

* * * * *

[page 2]
PURPOSE AND SUMMARY

The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.

Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill. In addition, hospitals and physicians

that discipline doctors will be required to report these disciplinary actions to the state medical boards. In turn, the state medical boards will be required to forward this information to the Secretary of the Department of Health and Human Services (" the Secretary") or the Secretary's designee. The bill further requires hospitals to seek this information from the Secretary, or the Secretary's designee, before hiring doctors or other licensed health care practitioners.

The bill also requires paid malpractice claims to be reported to the Secretary, or the Secretary's designee.

BACKGROUND AND NEED FOR THE LEGISLATION

The Committee has reviewed testimony from numerous sources indicating that this legislation is essential to protect the public health and safety.

This bill is needed to deal with one important aspect of the medical malpractice problem in this country--incompetent and unprofessional physicians. It does not address the malpractice insurance crisis, which has extremely complex and controversial origins and cannot be solved through peer review. The bill's focus is on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues but are dealt with in a way that allows them to continue to injure patients.

HEALTH PROGRAMS
P.L. 99-660

Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all to [*sic*] easy to move to different hospitals or states and continue their practices in these new locations.

The result has been a series of highly visible situations in which physicians with a long history of incompetence or unprofessional conduct have continued to cause needless deaths and injury for years after their damaging behavior was noticed. This legislation would do much to reduce the damage committed by this small, but very destructive, group of doctors. It would require organizations that discipline doctors to report their disciplinary actions to a central location and would require hospitals to seek this information before hiring doctors. It would also require the reporting and dissemination of paid malpractice claims.

To assure that the medical profession cooperates in this system, the Committee believes it is essential to provide some legal immunity to doctors and hospitals that engage in peer review activities. [a]s noted above, under current law and practice, physicians who

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engage in incompetent or unprofessional acts find it very convenient to move to another jurisdiction and resume practice. There are two reasons for this. One is that hospitals too often accept "voluntary" resignations of incompetent doctors in return for the hospital's silence about the reasons for the resignations. Hospitals make these agreements in order to

avoid lengthy and unpredictable litigation. The other is that there is no comprehensive national reporting system to follow bad doctors from place to place.

The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another. The reporting system, however, creates a major problem. Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation. The reason: faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience the Committee believes that many of these physicians will file antitrust lawsuits.

Even though defendants may often win these lawsuits, that may not be sufficient to guarantee enthusiastic or even minimally adequate, peer review. Unlike other activities that may trigger antitrust lawsuits, properly limited peer review plays no essential or important economic role in the practice of medicine. Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review. The result would be to continue the possibilities for abuse by bad doctors.

Thus, there is a clear need to do something to provide protection for doctors engaging in peer review if this reporting system is to be workable. To that end, the bill provides limited, but essential, immunity. Doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of the bill are protected from damages sought by a disciplined doctor. The

LEGISLATIVE HISTORY
P.L. 99-660

bill protects innocent and often helpless consumers from abuses by bad doctors without insulating improper anti-competitive behavior from redress.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on H.R. 5110 (and the related bill, H.R. 4390) on July 16, 1986. Testimony was received from 12 witnesses, representing 11 organizations. One witness was a medical director who bad hired numerous physicians without being able to discover even well documented -- sometimes with tragic consequences. Other witnesses represented hospital associations, medical professional groups, the Inspector General of the Department of Health and Human Services, large employers, the Federation of State Medical Boards, and the U.S. General Accounting Office.

COMMITTEE CONSIDERATION

On September 17, 1986, the Subcommittee on Health and the Environment met in open session and considered the bill H.R. 5110. The bill was ordered reported as amended, to be introduced as a

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clean bill, by a voice vote, a quorum being present. On September 18, 1986, the Committee met in open session and ordered reported the clean bill H.R.5540, without amendment by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will have a negligible budget effect for fiscal year 1987 and thereafter because of savings that should result from implementing the reporting system. In the short term, savings would be expected from reductions in the volume of payments under federal programs for unnecessary care or care that is delivered incompetently and results in the need for additional services. In the longer term, savings would also be expected to result from relatively lower hospital expenses for liability insurance.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., September 22, 1986.

HEALTH PROGRAMS
P.L. 99-660

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 5540, the Health Care Quality Improvement Act of 1986, as ordered reported by the Committee on Energy and Commerce on September 18, 1986. The bill would encourage hospitals, insurance companies, and other health care entities to report information concerning medical malpractice payments, sanctions for professional incompetence or misconduct, and other professional review actions taken against health care providers. In exchange for reporting, this bill would grant immunity under federal law to hospitals and individuals.

H.R. 5540 would establish a health care provider information clearinghouse to collect and disseminate the reported information on health care providers. The clearinghouse would be run by the Secretary of Health and Human & Services (HHS) or, at the Secretary's discretion, by an appropriate public or private agency. If the clearinghouse is run by HHS, CBO estimates that enactment of this bill could result in costs to the federal government of $30 million in fiscal year 1987 and $10 million in each fiscal year thereafter. If however, the Secretary exercises his discretion to appoint a

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private agency to operate the clearinghouse system, the cost to the federal government could be insignificant.

Hospitals would be required to request information from the clearinghouse prior to hiring any licensed health care

professional applicant. Also, at least every two years each hospital would be required to request information on each member of its medical staff. All of the costs associated with information reported would be borne by private hospitals, insurance companies, boards of medical examiners, and other health care entitles.

Both the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) maintain data bases containing information similar to that required under the bill. The data collection activities described in this bill would be much more extensive than any that currently exist. Based on rough estimates provided by the AMA, this bill could require approximately one million hospital staff member credential checks per year. In fiscal year 1987, it could cost about $30 million to create the comprehensive data base, to operate the system, and to respond to credential check inquiries. For each fiscal year thereafter, the federal government could expect a cost of about $10 million to maintain and operate the system. These rough estimates reflect the costs of operating a clearinghouse for information only on physicians. Additional costs could be expected since the bill requires the data base to include information on *all* licensed health care professional, not just physicians.

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Please call me or have your staff contact Marianne Deignan (226-2820) if you have further questions.

With best wishes,

Sincerely,

Edward Gramlich
(For Rudolph G. Penner, Director).

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4)) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee reports that enactment of this measure will not have an inflationary impact on the economy. The bill is intended to improve public health and safety by reducing the number of injuries and deaths associated with incompetent or unprofessional medical care by physicians. By reducing the costs associated with incompetent and unprofessional physicians, the bill is likely to have a favorable effect with respect to inflation.

SECTION-BY-SECTION ANALYSIS

Section 1

Short Title and Table of Contents.

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Title I- Promotion of professional review activities

Section 101

Precludes damages against professional review bodies and persons taking professional review actions that meet the standards defined in section 102.

Provides immunity for persons providing information to professional review bodies without knowledge that the information is false.

Suspends protection against damages if health care entity does not comply with reporting requirements of section 203.

Section 102

For a professional review action to qualify for protection from damages it must be taken:

In the reasonable belief that it is in furtherance of quality care;

After a reasonable effort to obtain facts;

After adequate due process;

In the reasonable belief that the action was warranted by facts known.

Characteristics of due process that would be deemed adequate:

Notice of action, with reasons specified;

Right to hearing with notice of time, place, date, and witnesses to testify;

Hearing held before arbitrator or hearing officer or panel not in direct economic competition with physician involved;

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Right to representation, to copies of the record, to call and examine witnesses, to present evidence, and submit written statement;

Right to receive written recommendation and decision. Due process can be different in health emergencies or under other applicable law.

Section 103

Court permitted to award attorneys' fees to defendant who prevails and whose professional review action met standards of the bill.

Court may not award attorneys' fees to plaintiff unless it determines that it would be appropriate to do so.

Section 104

Secretary of the Department of Health and Human Services may establish voluntary guidelines to assist professional review bodies in meeting standards.

Section 105

Activities not covered by this legislation remain under current law, including activities regarding nurses or other practitioners who are not physicians.

Bill creates no requirement that health care entities grant clinical privileges to any or all health care practitioners.

Section 106

Bill applies to actions commenced on or after effective date.

Title II- Reporting of Information

Section 201

Information on paid malpractice claims must be reported to Secretary or designee.

Civil monetary penalties provided for failure to report.

Secretary to study need to report on small payments and also on all claims made.

Section 202

Boards of Medical Examiners must report to Secretary when physician licenses are revoked, suspended, or other actions are taken for reasons relating to competence or professional conduct, or when licenses are surrendered.

Sanction for failure to report is loss of designation under Section 203.

Section 203

Health care entities that take actions adversely affecting clinical privileges for 30 days, that accept privileges during or to avoid an investigation, or that take actions adversely affecting professional society membership, must report information on such actions to the Board of Medical Examiners in that state.

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Health care entities permitted to report similar actions respecting practitioners who are not physicians.

Boards of Medical Examiners must in turn report such information to the Secretary or designee.

Section 204

Reporting must be not less often than monthly and in form and manner prescribed by Secretary.

Secretary of the Department of Health and Human Services may designate an appropriate private or public agency for receipt of required reports. .

Malpractice information reported to Secretary must also be reported to appropriate state Board.

Section 205

Hospitals required to request information reported to Secretary or designee when physician or other practitioner applies to be on staff, and biennially thereafter.

Sanction for failure to report is that hospital is presumed to have such information in a medical malpractice action.

Hospitals relying on such information not known to be false are protected.

Section 206

Secretary must provide for disclosure of information to affected practitioner, and for procedures in case of disputed accuracy.

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Section 207

Secretary authorized to provide information to other health care entities and to State boards, upon request.

Information reported to Secretary is considered confidential, except with respect to professional review activity, medical malpractice actions, or other specifically authorized disclosures.

Civil monetary penalties for violations of confidentiality.

Persons reporting information protected in absence of knowledge that information was false.

Payments of malpractice claims not to be construed as creating presumption that malpractice has occurred.

Title III- Definitions and reports

Section 301

Various definitions.

Professional review action not considered to be based on "competence or professional conduct" if it is based on:

Relationship with professional society or association;

Advertising, charging lower fees, or engaging in other competitive acts;

Financial arrangement for delivering health care;

Relationship with practitioners who are not physicians.

Professional societies not eligible for protection if they have been found to have engaged in anti-competitive practices restricting the practice of other practitioners within previous 5 years.

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Section 302

Secretary to report annually for three years on implementation of this legislation

Secretary of the Department of Health and Human Services to seek to enter into memoranda of understanding with Secretary of Defense and Administrator of Veterans Affairs to apply provisions of legislation to facilities and personnel under their jurisdiction.

Secretary of the Department of Health and Human Services to seek to enter into memorandum of understanding with Administrator of Drug Enforcement Administration concerning revocations of registration to dispense controlled substances.

DISCUSSION: COMMITTEE VIEWS

Title I - Promotion of professional review activities

Section 101. Professional Review

Subsection (a) provides limited, but essential, protection from liability for persons conducting professional review actions based on the competence or professional conduct of individual physicians. To qualify for the protection, the professional review action must meet the standards specified in section 102(a) and must be an action as defined in section 301(9). If those criteria are met, the persons engaging in or assisting in the conduct of professional review action shall not be liable in damages with respect to the action.

The Committee feels that the purposes of this bill

require protection for persons engaging in professional review. Under current

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state law, most professional review activities are protected by immunity and confidentiality provisions. A small but growing number of recent federal antitrust actions, however, have been used to override those protections. Because the reporting system required under the legislation will most likely increase the volume of such suits, the Committee feels that some immunity for the peer review process is necessary.

Initially, the Committee considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill. The bill leaves completely intact the jurisdiction of the Federal Trade Commission, the Justice Department and State Attorneys General to bring antitrust actions. In addition, the bill does not restrict the rights of physicians who are disciplined to bring private causes of action for injunctive or declaratory relief. If the professional review actions being challenged fail to meet the standards of section 102(a), no immunity is provided and the suit can be tried without regard to the provisions of this bill.

Subsection (a) also provides immunity for persons providing information to professional review bodies, unless the information is false and the person providing the information actually knows it is false. The Committee intended to encourage persons to report in-

formation regarding possible incompetence or unprofessional behavior on the part of physicians. Such persons might have no connection with a professional review body, and thus the Committee determined that such immunity would not be made contingent on the propriety of the actions of the professional review body.

Subsection (b) bars immunity for health care entities that do not participate fully in the reporting requirements of section 203(a). The approach used in this legislation reflects the Committee's strong feeling that the current problem of incompetent or unprofessional physicians being able to disappear and leave their history behind must end. This problem can be solved only if hospitals and other health care entities make their findings available to each other through the reporting systems established in this legislation.

Simply conducting professional review to rid a single hospital or a single community of a problem physician without reporting the action is not sufficient to warrant the protection provided under this legislation. Accordingly, health care entities that do not report do not get immunity under this bill. This does not mean that minor or technical flaws in reporting will trigger the loss of immunity. To protect health care entities in this regard, the Secretary is required to follow specified procedures prior to suspending or disqualifying them from the immunity provisions.

The fact that a professional review action was or was not taken against a physician under this bill shall in no way affect the right of a patient to file a malpractice claim or action for damages. Nor shall such failure affect any defenses to such a malpractice action. For example, a patient might seek to include a hospital in a malpractice action where the hospital

has information related to the

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professional conduct or competence of a physician, takes a professional review action that meets the standards of this bill, exonerates the physician, and the patient is subsequently injured by the physician. Although the hospital and the professional review body would not be subject to damages in a suit by the physician, this immunity would not apply to any suit by the patient.

Although the secretary is required to work with health care entities to bring them into compliance, the Secretary is also obligated to act should the Secretary suspect that these entities are out of compliance. The bill requires the Secretary to conduct an investigation whenever the Secretary has reason to believe that a health care entity has failed to report appropriately. Thus, if professional reviewers or even members of the general public notify the Secretary that a hospital is out of compliance, the Secretary will be required to conduct an investigation.

Section 102. Standards for professional review actions Subsection (a) establishes the standards that a professional review action must meet in order to qualify for immunity under section 101. The first requirement is that the action be taken in the reasonable belief that it is in the furtherance of quality health care. Initially, the Committee considered a "good faith" standard for professional review actions. In response to concerns that "good faith" might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional

review action, the Committee changed to a more objective "reasonable belief" standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.

Reflecting the Committee's belief that this standard will be met in the overwhelming majority of professional review actions, the subsection provides a presumption to that effect, requiring a plaintiff to show, by clear and convincing evidence, that no such reasonable belief existed at the time of the professional review action. This presumption applies only to the reasonable belief standard, not to the other standards. Those additional standards require a group engaged in peer review to make a reasonable effort to obtain the facts to provide adequate due process, and to have a reasonable belief that the professional review action was warranted by the facts known.

The due process requirement can always be met by the procedures specified in subsection (b). If the procedures specified in that subsection are provided, the health care entity will be deemed to have met the due process standard. If other procedures are followed, but are not precisely of the character spelled out in subsection 102(b), the test of "adequacy" may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decisions regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the "adequacy" requirement even where such activities or ac-

tions require different or fewer due process rights than the ones specified under subsection 102(b). In any case, it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.

The Committee intends that the hearing panel or officer be impartial and fair in evaluating a physicians behavior. In order to ensure that reviews of physicians pertain only to quality of care, the Committee has specified that members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent. The Committee recognizes that in many cases, such as small hospitals or group practices, hospitals or physicians in rural areas, or situations involving highly specialized work, this requirement may represent some difficulty. In particular, it may not be feasible to find physicians who are of the same specialty as the respondent but who are not in direct tn economic competition. Nevertheless, the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing in reviewers from out of town or using physicians of a different specialty.

The Committee also notes that the failure to meet the standards of Subsection 102(a) creates no presumption with respect to the liability or lack of liability of a health care entity. Such failure would, therefore, be inadmissible in evidence in any litigation be-

tween a physician and any person or group engaged in peer review. The only conclusion that follows from a failure to meet those standards is that the entity is not entitled to the immunity conferred under this legislature. The entity is still entitled to the full range of defenses and immunities available under other applicable law and practice.

One of the requirements of due process is notice. The Committee is aware that between the time the initial notice is given of a proposed professional review action and the time of the hearing on that action, the investigation may have uncovered reasons for such an action other than or in addition to the reasons specified in the initial notice. Provided that notice is given in a way that protects the interests of the physicians against whom the action is proposed, a supplemental notice of such additional reasons might well satisfy the requirements of due process.

Subsection (c) modifies the due process required to obtain immunity under section 101(a) during investigations or in health emergencies. Under this provision there is no requirement that due process meet a test of "adequacy" where no adverse professional review action is taken (e.g., an investigation resulting in a decision not to take a professional review action), or during a suspension or restriction of clinical privileges for a period of not longer than 14 days during an investigation to determine the need for a professional review action. In addition due process can be provided after the fact where clinical privileges are suspended or restricted on an immediate basis where the failure to take such action might result in an imminent danger to the health of an individual.

The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection

during investigations and to allow quick action where it would be reasonable to

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conclude that someone's health might otherwise suffer. Nevertheless, these exceptions are not meant to provide a back door for harassment of physicians through repeated short term suspensions or interminable investigations never leading to a professional review action. Such actions could not meet the "reasonable belief" test in subsection 101(a). Health care entities should bring a full-fledged professional review action where such instances repeatedly recur with regard to a specific physician.

The Committee intends that these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. The provisions would allow a court to make a determination that the defendant has or has not met the standards specified in section 102(a). The Committee intends that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of litigation that the defendant has met the 102(a) standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity. In such a case the court could still proceed to determine whether injunctive, declaratory, or other relief would be in order.

I think there are studies which establish that indigent patients tend to have a higher post-op infection rate than non-indigent patients.

Is that something that should be subject to peer review?

Dr. WOLFE. It should not be subject if one looks at those two categories--competence, or the lack of competence, incompetent behavior or lack of professional conduct - the studies showing a significant portion of psychiatrists have sexual relations with their patients is clearly not professional conduct.

In this case, you are describing something that is competent and necessary behavior, and would fall outside of the immunity. If a hospital tried to take action against a physician because the physician happened to be more concerned with poor people and had a practice made up more largely of poor people than someone else, that should be the subject of reward, not discipline. I don't think that would even arguably fall within the immunity provisions of this bill.

Mr. EDWARDS. Thank you.

Without objection, the statement of the distinguished Chairman of the Subcommittee on Health and the Environment, Mr. Waxman, and other members of the subcommittee, Messrs. Tauke and Wyden, will be included in the record immediately after the opening statement by Mr. Sensenbrenner.

We are going to have to take a recess for about 10 minutes while we vote. In that period of time, the committee will be recessed.

[Recess.]

Mr. EDWARDS. The subcommittee will come to order.

Minority counsel, Mr. Slobodin.

Mr. SLOBODIN. Thank you, Mr. Chairman.

Dr. Wolfe, I just wanted to see if I could get a better idea of exactly what your position is on the bill at this time. Is it your position that we should, despite some differences you have with the way the bill stands now, it should be enacted in this Congress?

Dr. WOLFE. Well, I think the differences I raise are important ones and they need to be addressed. I don't think they are ones that are insurmountable. The very fact that there was concern about the immunity being too broad initially has led to a whole host of changes such as actions brought by the Justice Department or the FTC are not in the immune category.

The four categories I read and two additional ones I think are critical. If those are not added, we would not support the bill. We are very concerned with the immunity being too broad and anything that can be done to narrow it, such as what has been done already, what I have suggested and there may be other people who have other suggestions, needs to be done.

But the overall-purpose is that we have a real crisis in this country of inadequate discipline of physicians. The hospital level, which may be the most underdone one right now is very much threatened by the Oregon case and lots of others like lt.

Every physician I know in the country who is practicing medicine tells me that there are one or more physicians at his or her hospital who are incompetent and when I say why are they still there, they say we are afraid to bring an action against them be cause they will retaliate and so forth.

Our system of criminal justice provides not merely protection for society by permitting society to rid itself of persons who cause problems, but also a system of protection for persons who are accused and it turns out wrongfully accused. Indeed, we glory in that fact. That is what makes our system of justice a system of justice rather than a system of irrational punishment. In the same way, I say to this committee that it should be an express purpose, not implied, not somehow found somewhere underneath some of the provisions, to protect doctors whose right and whose privileges and whose ability to practice their livelihood may be, and I submit will be wrongfully called into question by procedures permissible under some of the due process provisions of this bill. That is where my problems lie. I remember back in law school we debated the question whether it was indeed true that a criminal justice system is better if it permits a guilty man to go free rather than convicting an innocent man. That is a philosophical issue on which people may differ. Our system, I believe, is based on the theory that it is better for the guilty to go free than the innocent to be convicted. In legislation of the sort, before this committee, a similar principle operates. That is, in a system designed to weed out rotten apples there must be safeguards, through legislation, that "weeding out" not happen wrongfully.

There was testimony this morning, for example, that there was no doubt that were adverse peer review imposed upon a physician because he or she served black patients, or poor patients that that wouldn't come under the immunity provision of this bill. Certainly it wouldn't come within the intent of the immunity, but the committee can take notice, I believe, that when some doctors decide to get rid of the doctor who is serving the black or poor patients, they are not going

to say that is why they are doing it. They are going to say they are doing it because he is not providing good services. It is the same in any employment discrimination case. We are living in 1986, not 1966 or 1956. They don't say get rid of doctors who serve the poor or the minorities. They say he is not providing good patient care. And my goodness, he was a really good doctor until about a year ago. We just don't know what happened. He went bad, and take a look at these records which we've dug up.

We have a real problem, a real problem.

I have seen these things, I have litigated these things. I have heard them. They do happen. They will happen.

Those problems are caught up in this legislation. It is necessary not merely to attempt to legislate a mechanism to weed out the incompetence, but also to institute safeguards so that the wrongfully accused will have a way to get out to the extent available through legislation. The question is what are the implications of these concerns for this particular bill and some of the particular provisions in this bill which I would like to address by specific reference.

I may say that my own guide in going through this bill has really been cases that I have worked on, cases in which I have worked administratively and in the courts for physicians--turns out, physicians who, almost without exception, were foreign medical graduates. I don't consider myself a foreign medical specialist. I am prepared to work for any doctor who walks in the door if the case seems to be an appropriate case.

present form, in attempting to deal with that problem, has implications for doctors who are unfairly accused for hidden agendas and the need to build in safeguards which will protect them.

Mr. EDWARDS. Well, your problems also have to do, Mr. Glasberg, with the present system. The present system is inadequate insofar as you are concerned.

Mr. GLASBERG. Well, that is certainly true, sir. Right now all I can do is address the proposed bill here.

Mr. EDWARDS. Very good.

Mr. GLASBERG. The way in which the system works, its unfairness is through denial of procedural due process. No hospital committee is going to expel a doctor for an expressly illegitimate reason of the sort that the witnesses before you are concerned about. They are going to use the loopholes and the vagueness and the various problems with the due process provisions of these kinds of procedures to do that, which is why I fastened on them, as they now use just these types of loopholes common under the current state of affairs, which is basically JCAH-approved bylaws subject to minimal state scrutiny.

Mr. EDWARDS. You want Congress to clean up the situation by taking a bill such as this and inserting into it due process safeguards that would protect physicians?

Mr. GLASBERG. I think that would be a very excellent step, yes,

Mr. EDWARDS. Do you think that this bill could be so amended?

Mr. GLASBERG. I certainly do.

Mr. EDWARDS. And if it were so amended, would you be in favor of it?

Mr. GLASBERG. Yes, sir.

Mr. EDWARDS. Ms. Farray, do you feel the same way, that peer review is important and that we should support and assist such review. Is it your view that this bill is necessary with improvements?

Ms. FARRAY. Yes, sir; I do. After having been a practicing hospital administrator for nearly a decade, I was impressed with the need for a fair and equitable means to review, on a continuing basis, the professional competence of physicians. I feel there is no less need to review the professional competence of minority physicians who take care of the poor. I think the process, however, should be a fair and equitable one.

Mr. EDWARDS. That is very interesting. All three witnesses would be in favor of this type of Federal involvement, but would also agree that the bill should be beefed up with constitutionally appropriate protections. And I think that we will agree that the anti-trust issue has largely been put to rest by, I believe, three circuits; is that correct?

Mr. GLASBERG. So far as I am aware, there is no substantial Federal authority, I think there are one or two cases, suggesting Sherman.

Mr. EDWARDS. I believe I will yield to counsel.

Ms. DAVIS. Thank you, Mr. Chairman.

I would like to address this question to the attorneys on the panel based on your experience with cases challenging peer review.

As I understand it, it is anticipated that as a result of the reporting

all should be disclosed to the public? That is not part of this bill but this was an area where Dr. Wolfe felt the reporting provisions ought to be strengthened.

Mr. GLASBERG. Having heard that first an hour or two ago, I am not sure how fully I can respond on that. Settlements are very often notoriously misleading guides to anything that happened and it is not clear to me that the probative value of a settlement would be the same as that of the other information to be reported.

I think it is an issue that might well be probed and--

Mr. SLOBODIN. Do you think if such a reporting requirement that Dr. Wolfe suggests were adopted in this bill that it would increase litigation, there would be less incentive to settle as is? I think the American Medical Association pointed out that they felt that this would be a problem with some of these tougher reporting requirements. Does that sound realistic at all?

Ms FARRAY. I don't believe so. I think the fact of mounting a suit is something that is very repugnant, in fact, to most physicians. It is a long and costly process both in terms of dollars to them and in terms of the professional reputation and their ability to earn a living.

Also, the fact that a physician is known as having been litigious or mounting a suit at all is not something in their favor in seeking admitting privileges or expanding their practice in most hospitals around the country.

Mr. SLOBODIN. Has there ever been--is anybody on the panel aware of any studies that have been done on states that have shield laws, comparing those states and their experience in trying to curb incompetent practices in the medical profession as opposed to states that don't have the shield laws?

Ms. FARRAY. I am not.

Mr. GLASBERG. Other than what Dr. Wolfe testified to earlier, no.

Mr. SLOBODIN. No further questions.

Thank you, Mr. Chairman.

Ms. DAVIS. I have one further question, Mr. Chairman, and that is you were all very thorough in your comments on the language in the bill. Dr. Wolfe did suggest in his testimony that the breadth of the immunity was limited by the language set out in Section 301, Part 9.

If I am correctly stating his point, if the peer review committee is really used as a subterfuge for some other activity, the immunity will not apply and, therefore, the affected doctor could get damages.

Mr. GLASBERG. The problem is the very nature of the subterfuge, if you will, the hidden agenda is not articulated, so it may very well be the fact that an action would turn out, in the judgment of a jury or in any reasonable person's judgment, to be predicated upon some of the facts set forth in Paragraph 9, but is not presented as such. It is presented on the basis that we reviewed your chart and we found your work isn't any good. Any litigating lawyer, anybody who reads the paper is aware that you can always find a doctor to say anything about anything.

You can get a doctor to say this case was properly done, you can get another doctor to say the case was improperly done, good judgment was exercised, poor judgment was exercised. That is the

The other half of the problem is the fact that the health care profession is, and is becoming even more so every day, a competitive environment. There was a time when there was no thought given, really, to cost containment, where any physician who passed his or her boards was likely to find membership on a medical staff of the choosing of that physician. That no longer is true, and we find that medical staffs are starting to close their membership where they used to be open. Hospitals are finding that they have unfilled beds. There is true competition that is increasing among all levels of health care provision.

Particularly in that environment, it seems to me that the provisions of Title I are extremely dangerous. Let me explain. We have a variety of rights in this country, both as consumers and as practitioners. The bill currently would wipe out very basic fundamental statutes of our country as they apply to health care providers. The civil rights statutes and I am talking about the antitrust laws, and I am talking about as well something that frequently is not addressed in the consideration of these bills, State laws, which have the same kinds of intents.

Now in many States there is either an antitrust act or there is a common law basis for avoiding, and recovering damages in the event of, unfair competition. Likewise, many States have civil rights acts that in some respects go beyond and provide greater protection to members of minorities and nonminorities than is provided by Federal statute. New York has its civil rights act, as do California and a number of other major States.

The bill would make no differentiation among these various protections, and would wipe out what is frequently the only basic right of someone who is an innocent practitioner--I will call the reviewed physician that--under those various

provisions. My concern is for the physician who is wrongfully the target of a peer review action.

I do not think that it can be presumed, as the bill purports to presume, that the action taken in peer review is necessarily for the betterment of health care provision. To the contrary, particularly in light of the increased competition among providers--I am talking about physicians particularly--the likelihood is that that process will be abused for anticompetitive or what I would call antisocial purposes.

The bill, over and above the sweeping policy problems of providing this blanket immunity, also raises substantial doubt as to how it will actually be enforced. That is particularly dangerous in a situation where we are talking about fundamental rights.

I want to digress for one moment. Much has been said, both in these committee proceedings and in the media, about how antitrust suits are abused. Respectfully, I disagree based upon considerable experience, both in and out of the health care profession, representing plaintiffs and defendants in antitrust actions. Congress clearly intended to further antitrust enforcement by private entities, knowing that the Federal Government's resources are limited. That goes both for the FTC and for the Justice Department, and both of those agencies have endorsed the concept of private actions to enforce by supplementation the antitrust laws.

Mr. SEYMOUR. I would agree with the other witnesses but offer an illustration. Presently under the civil rights laws, as well as, I understand, under the antitrust laws, a prevailing defendant may obtain an award of attorneys' fees if the suit is frivolous, vexatious, if it is baseless, or if it is maintained after the plaintiff has reason to understand that it no longer has an adequate basis. Then the defendant under the existing laws can receive an award of attorneys' fees.

The effect of the standard here is to create a right to attorneys' fees where that right would not exist under the civil rights laws. About cases which are fairly arguable, in which there is some substantial evidence the plaintiff was going on, this bill would give a right to defendants to seek fees even where there is good-faith litigation backed up by substantial evidence, and we do not think that is proper. If the case is baseless, there already is a right to recovery on the part of the defendant.

Moreover, in the conduct of the litigation itself, a defendant can seek sanctions under Rule 11, including attorneys' fees, if any part of the litigation is conducted frivolously or vexatiously. There are existing State law rights for abuse of process pursuant to which any of the defendants on these professional review bodies may sue because the lawsuit was frivolously based. So there seems to be no real purpose served by the attorneys' fees provision. No good purpose served by it.

Mr. WEINSTEIN. I would like to add one further comment to that which was just made, and that is very recently the United States Court of Appeals for the Third Circuit, in applying Rule 11 of the Federal Rules of Civil Procedure made it abundantly clear the courts of that circuit are to focus more on the question of the amount of attorneys' fees and other

sanctions to be imposed rather than whether or not to impose the sanctions.

So there is a reawakening by the courts generally, as demonstrated by that case, that the appropriate case can be grounds for sanctions. Whether or not one could recover in fact in a State abuse of process action, the Federal courts are very sensitive to it. Rule 11 was recently in the last few years beefed up, and the courts are responding to that amendment.

Ms. DAVIS. I have one last question and it is in response to testimony heard yesterday, and in our need to understand how peer review has operated thus far. Is it sometimes possible that a physician will be denied privileges because a doctor's patient load has a high proportion of uninsured or indigent persons, and if that is possible, are you convinced that the bill presently is drafted in such a way to prevent that being part of a peer review on the question of competency and professional conduct?

Mr. HALPER. I am sure that, if you are going to deny privileges to anyone, you normally have to follow procedures. The right judgment result is another question. I would suppose someone wanting to process that case against a particular physician under those grounds would use the rubric "quality of care" or something like that, and in that case you probably could have an abuse. It more likely would be an abuse if you leave in the words "professional competency" rather than "quality of care." That was my point earlier. Quality of care is harder to define except in terms of actual

procedures. "Professional conduct" masks a lot of other types of activity.

Mr. WEINSTEIN. And so does professional conduct, whatever that may mean. Yes, I think there is very realistically such a possibility in this day and age where hospitals--leaving apart now physicians--hospitals are concerned about their profitability. We run the risk with this bill that a practitioner is going to have a negative mark reported nationwide merely because of the nature of the population that he or she serves. That is really something that we do not want to encourage.

Ms. DAVIS. Thank you, Mr. Chairman.

Mr. EDWARDS. Counsel.

Mr. SLOBODIN. No questions, Mr. Chairman.

Mr. EDWARDS. Thank you very much, gentlemen. We appreciate your coming here, especially on such short notice and giving such expert testimony. We are very grateful.

The last panel today is composed of Dr. William T. Mixson of Coral Gables, Florida, Immediate Past President of the American College of Obstetricians and Gynecologists, and Dr. W. Michael Byrd, of Tyler, Texas. Dr. Mixson, we welcome you. Without objection, the full statements of both Dr. Mixson and Byrd will he made a part of the record. We welcome you and will hear from Mr. Mixson first.

STATEMENTS OF WILLIAM T. MIXSON, M.D., CORAL GABLES, FLORIDA, IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; AND W. MICHAEL BYRD, M.D., TYLER TEXAS

Dr. Mixon. Thank you. I am testifying on behalf of the American College of Obstetricians and Gynecologists. I am

particularly pleased to have the opportunity to comment on 5540 because peer review is one of the major planks in my activity last year. I want to commend the members of the committee, and its staff also, for the prompt scheduling of the hearing so that the Congress does have the opportunity to consider this important legislation before adjournment. My written statement covers in detail the college's view on immunity and reporting provisions of H.R. 5540. In the interest of time, I will concentrate on a few points I believe are key to the members of the committee.

Physicians have been told to police bad doctors, to police themselves and get rid of bad doctors. Nobody dislikes bad doctors more than we do. The legitimate physician finds them especially bad. They hurt us all. Our specialty has a long history of self-review and criticism. Maternal mortality committees were born in the 1920s, and as a result of this voluntary peer review, maternal mortality rates have dropped dramatically so that now it is at the lowest level and childbirth is a relatively safe procedure.

We also have continuing peer review activity going on all the time. Quality assurance, tissue committees, transfusion committees, et cetera. These are all part of our everyday professional life. In spite of all of these efforts, we can do better, and we must do better.

* * *

This bill focuses on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues, but are dealt with in a way that allows them to continue to injure patients. The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another without detection.

The limited immunity provided under this bill is essential to encourage physicians and hospitals to participate in conducting effective peer review. The immunity provisions have been restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions that violate civil rights laws or actions that are really taken for anticompetitive purposes will not be protected under this bill.

As floor manager for the bill H.R. 5540, the Health Care Quality Improvement Act of 1986, submits on behalf of the Committee on Energy and Commerce the following comments concerning changes in the bill made subsequent to the filing of the report (99-903, part I) on the bill by the Committee on Energy and Commerce. These amendments were developed largely in response to concerns raised by the Committee on the Judiciary.

AMENDMENT NO. 1

Page 2, line 8, insert "all" after "meets."

This amendment clarifies the requirement that the standards of section 102(a) must be met in full to receive the protections provided under section 101(a).

* * *

AMENDMENT NO. 5

Page 4, line 6, strike "The" and all that follows through "taken" on line 8 and insert: "For purposes of the protection set forth in section 101(a), a professional review action must be taken."

This amendment clarifies that the protections of section 101(a) are available only for professional review actions that meet the standards of section 102(a).

AMENDMENT NO. 6

Page 4, line 13, strike out "due process" and insert "notice and hearing procedures are afforded."

Page 4, line 14, insert before the comma the following: "or after such other procedures as are fair to the physician under the circumstances."

* * *

AMENDMENT NO. 7

* * *

As adopted by the Committee on Energy and Commerce, the legislative language also permitted another unintended interpretation, viz., that the other three standards would have to be pleaded and proved by the defendant as an affirmative defense. Such an interpretation would have shifted the normal burden of proof for civil trials and was never intended by the Committee on Energy and Commerce. (Similarly, nothing in this bill is intended to expand or narrow current discovery rights under State or Federal laws. [*sic*]

This amendment is intended to clarify and simplify the requirements concerning the burden and standard of proof. All four standards are now treated similarly. The standard concerning whether the action was in furtherance of the quality of care still has the benefit of a presumption, but now that presumption is to be overcome by a preponderance of the evidence. Similarly, the amendment now makes clear that the burden of proof with respect to the other three standards is the same as that for subsection 102(a)(1) and rests on the plaintiff, not the defendant or defendants.

* * *

AMENDMENT NO. 10

* * *

Page 23, line 13, before the period add the following:

"(E) the intent to retaliate illegally against a physician who, prior to the commencement of an investigation regarding the physician's competence or professional conduct, raised legitimate questions regarding the quality of health care of the health care entity, or

"(F) any other matter that does not relate to the competence or professional conduct of a physician."

This amendment clarifies the exclusions from matters that can be considered to be related to the competence or professional conduct of a physician. The change in paragraph (B) is to clarify that actions taken to enforce illegal price-fixing arrangements are not protected under the bill.

New paragraph (E) makes explicit that professional review actions taken in retaliation against whistleblowers are not protected under the bill. This exclusion is in response to concerns raised by a witness before the Judiciary Committee's Subcommittee on Civil and Constitutional Rights about the problems facing whistleblowers in some hospitals. It is not

intended to create a safe haven for incompetent or unprofessional physicians who seek to fend off legitimate professional review actions by suddenly questioning the competence or professional conduct of others. To qualify for this exclusion, a physician must convince a court that the professional review action was commenced after the physician had raised legitimate charges against the health care entity, and was initiated illegally in retaliation for the physician's having done so.

New paragraph (F) is intended to clarify that the list of exclusions is not exhaustive. This subsection reflects the concern that professionals review actions brought for illegitimate reasons may not appear as such on their face. Actions which specify, for example, that they are based on a physician's fees, or actions brought against a nonphysician practitioner, are clearly not eligible for protection under this bill. The more serious issues arise when actions are stated to be for legitimate reasons, but are challenged as not being genuinely based on the competence or professional conduct of an individual physician. It is, of course, the plaintiff physician's burden of pleading and proving to the court that the action was based on matters that do not relate to the physician's competence or professional conduct. The purpose of paragraph (F) is simply to avoid the interference that any matters not listed in this subsection are necessarily ones related to competence or professional conduct. For example, actions based solely on competitive considerations other than the ones enumerated in the bill would not qualify as being based on professional conduct or competence. For example, an action taken against a physician because of a style of practice or a pattern of patients that does not general sufficient revenue for a hospital would not be covered by this bill.

On the other hand, competence and professional conduct should be interpreted in a way that is sufficiently broad to

protect legitimate actions based on matters that raise concerns for patients or patient care. It would certainly include all specific conduct that could adversely affect the health or welfare of a patient or patients. This would include not only activities directly involving patients of the physician but also activities that raise the possibility of adversely affecting other patients. Such activities clearly would encompass felonies or crimes of moral turpitude. They would also include illicit transactions involving drugs, serious sexual offenses, violent behavior, and other similar acts.

Mr. Edwards of California.

* * *

Mr. Speaker, each one of our witnesses agreed that more effective physician peer review should and must be encouraged. But they unanimously agreed that the bill fails to adequately protect competent physicians from abusive actions by illegal professional review. In light of the Judiciary Committee's review, the chairman of the Subcommittee on Health and the Environment has made some significant changes to improve this bill; however, the fundamental flaw of the bill in its present form continues to be that the immunities shield professional actions which are fair as well as actions which are illegal.

COMMITTEE ON THE JUDICIARY.
Washington, D.C., October 10, 1986

Henry A. Waxman,
House Annex 1,
Washington, D.C.

Dear Henry: On September 29, the Judiciary Committee obtained a sequential referral of H.R. 5540, the "Health Care Quality Improvement Act of 1986." The initial referral ran through October 3. The referral was subsequently extended until Tuesday, October 14.

The bill was referred to the Subcommittee on Civil and Constitutional Rights to consider issues raised by the bill that fall within the jurisdiction of the Judiciary Committee. The Subcommittee just concluded two days of hearings on the bill. It was our intention in holding these hearings to provide a more complete record on the implications of the immunities and due process provisions set forth in Title I of H.R. 5540.

Our review would thus augment the hearing held on July 15, 1986 by the Subcommittee on Health and Environment.

* * *

The several witnesses presenting testimony to Judiciary were physicians (3), attorneys (6) and quality health care advocates (3) who are familiar with the peer review process. Each witness agreed that effective review of physicians is necessary to assure the delivery of competent, quality health care to all Americans. However, they stressed that the privileges of physicians should not be adversely affected through professional review action for reasons unrelated to competency. They agreed that the bill, as reported, does not provide adequate protections to competent physicians from abusive actions by illegal professional review.

* * *

The legal and constitutional problems created by this bill are many. We will summarize the most serious examples which were revealed during the Judiciary Committee's review of H.R. 5540. We found:

* * *

2. The bill establishes a statutory presumption that professional review actions are in the "furtherance of quality health care." It is a presumption which can only be overcome by "clear and convincing evidence." The presumption and burden of proof subvert existing law, with no compelling justification. Moreover, they would simply create additional legal issues to litigate in suits challenging review actions. A three-tiered system would result: one trial for injunctive relief, with one set of presumptions and burdens of proof and one trial to challenge the validity of the peer review action, with a different set of presumptions and burdens. If a physician were successful in the second suit, there would then be a third suit for damages. Such an approach is legally unsound, will add significant legal costs for both sides in an already costly proceeding, and frustrate the very purpose of the bill --

effective peer review through voluntary reporting.

* * *

We urge you to accept the findings and recommendations of the Committee on the Judiciary.

With kind regards.

Sincerely,

Don Edwards
Chairman, Subcommittee on Civil and Constitutional Rights.

* * *

Second the bill includes the provisions of the Health Care Quality Improvement Act, also passed by this House this week by voice vote. This bill is noncontroversial and has strong bipartisan support.

Mr. Speaker, the following comments pertain to title, this is title IV of the bill, which incorporates a modified version of H.R. 5540, the "Health Care Quality Improvement Act of 1986." H.R. 5540, as amended, passed the House on October 14.

These provisions have undergone a number of revisions during the legislative process. I stress this because most of the objections that were raised about earlier versions of H.R. 5540 (and its predecessor, H.R. 5110) have been addressed in recent drafts, and particularly in the provisions that are now before the House.

I would specifically note that my distinguished colleague from California, Don Edwards, the chairman of Judiciary's Subcommittee on Civil and Constitutional Rights, inserted his thoughtful letter of October 10 to me, and I would now insert a number of quotes from my response of October 14 to that letter. This is quite relevant since numerous revisions to the bill were made in response to the concerns raised in that letter. In addition, the bill that is now before us includes a number of other revisions worked out with the Senate. These changes--resulting in the final bill--address the remarks of Mr. Edwards.

* * *

BREADTH OF IMMUNITY

At one point, the scope of immunity in this bill was substantially broader than it is currently, in response to a number of valid criticisms, we narrowed the bill's scope in order to ensure that the jurisdiction of the Federal Trade

Commission, the Justice Department, the Equal Employment Opportunity Commission and State attorneys general remained intact. Furthermore, the only protection with regard to private actions is that damages are barred where the peer review group has acted properly in accordance with the four tests for reasonable belief, reasonable investigation and due process. Actions for reinstatement through injunctive and declaratory relief remain untouched. Finally, by the latest changes in H.R. 5540, we have completely removed from coverage any Federal or State civil rights laws. The immunity left after these modifications is extremely limited, but essential....

IMPLICATIONS OF THE REVERSAL OF PATRICK VERSUS BUGET [*sic*]

* * *

Nevertheless, I would make the following point with respect to the Patrick case and the antitrust laws. It is my understanding that a number of antitrust experts believe that the Ninth Circuit has extended the State action doctrine in Patrick farther than seems warranted by recent Supreme Court rulings. If appealed, the Patrick case may well be overruled or modified. If Patrick is upheld, the immunity from damages in antitrust actions granted by H.R. 5540 will be irrelevant in many States. If Patrick is overruled or modified, the immunity obtained under H.R. 5540 will be substantially narrower than the State action doctrine enunciated in that case. Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540.

Finally, the immunity contained in H.R. 5540, although promoted in part by antitrust concerns, addresses matters beyond the current antitrust laws. The reporting system in the bill is likely to stimulate a large number of lawsuits raising numerous legal theories -- many of them frivolous -- that will deter legitimate peer review activities unless some measure of protection is provided to those engaged in such activities.

* * *

NEED FOR A PRESUMPTION BASED ON CLEAR AND CONVINCING EVIDENCE

You object to the presumption regarding professional review actions that requires clear and convincing evidence. You suggest that it would create needless complexity in the minds of a jury to apply different standards, thereby adding to the

confusion and potential delay of a peer review trial in court.

Although I believe that the provisions of H.R. 5540, as drafted, are sound, I have modified the presumption to substitute the clear and convincing evidence test with a preponderance of the evidence test and to apply it uniformly. Such a step should simplify the immunity provisions and

---

make them easier to understand and apply.

* * *

§ 11112 Standards for professional review actions

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating -

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating -

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B) -

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) -

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right -

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right -

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

FILED
FEB 24 1995
CLERK OF THE COURT

(4)

No. 94-1323

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1994

FLOYD T. BRYAN, and
FLOYD T. BRYAN, M.D., P. A.

Petitioners,

vs.

JAMES E. HOLMES REGIONAL
MEDICAL CENTER, a/k/a/ HOLMES
REGIONAL MEDICAL CENTER, INC.

Respondent.

RESPONSE TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

February 23, 1995

Christopher K. Kay
Ronald M. Schirtzer
FOLEY & LARDNER
111 North Orange Ave.
Post Office Box 2193
Orlando, Florida 32802
(407) 423-7656

Alan C. Sundberg
Counsel of Record
Sylvia H. Walbolt
Gary L. Sasso
CARLTON, FIELDS, WARD,
EMMANUEL, SMITH &
CUTLER, P.A.
One Progress Plaza
Post Office Box 2861
St. Petersburg, Florida 33731
Attorneys for Respondents

BEST AVAILABLE COPY

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Sylvia H. Walbolt
Gary L. Sasso
CARLTON, FIELDS, WARD,
EMMANUEL, SMITH &
CUTLER, P.A.
One Progress Plaza
Post Office Box 2861
St. Petersburg, Florida 33731
Attorneys for Respondents

QUESTION PRESENTED

Whether the Eleventh Circuit Court of Appeals correctly determined that the Hospital was immune from liability for monetary damages under the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. §§ 11101-11152, where the court determined that all of the standards of the Act were met, including the presence of a "reasonable belief" on the part of the Hospital that its peer review action "was in furtherance of quality health care."

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STATEMENT OF THE CASE AND FACTS

Petitioners ask this Court to grant a writ of certiorari to review the decision of the Eleventh Circuit Court of Appeals holding that the respondent Hospital is immune under the Health Care Quality Improvement Act ("the HCQIA" or "the Act") from liability for monetary damages due to its decision to terminate staff privileges for Dr. Bryan. Petitioners' Statement of the Case omits or misstates the material facts relied on by the lower court in rendering its decision. Those facts and the procedural history of this case are set forth in detail in the lower court's opinion.[1/] They may be briefly summarized as follows.

Respondent Holmes Regional Medical Center is a non-profit corporation operating a private hospital in Melbourne, Florida.[2/] A. 15. Dr. Bryan was granted staff privileges in 1976 but he engaged in disruptive behavior from the outset of his association with the Hospital. A. 22-23. As noted in the Eleventh Circuit's opinion, Dr. Bryan "exhibited a pattern of unprofessional conduct over a period of many years, and he was given a series of opportunities to remedy his difficulties in interacting with other staff members." A. 44-45. Several illustrative incidents are described in the court's opinion. A. 24-25. Dr. Bryan conceded that the complaints about his conduct were not "fabrications" and that he had a problem with his temper and with his inter-personal dealings with his colleagues and the Hospital staff. A. 23; *see also* R18-1545, 1637, 1645.

Ultimately, the Hospital's Board of Directors advised Dr. Bryan that his abusive behavior would not be tolerated any longer and that any further incidents of unprofessional behavior would

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1/ The Eleventh Circuit's opinion is contained in Volume 1 of petitioners' appendix at A. 1-52.

2/ The Hospital has no parent companies or subsidiaries to be listed pursuant to Sup. Ct. R. 29.1.

result in the permanent revocation of his privileges. A. 26. When additional incidents nevertheless occurred, a peer review hearing was held, as provided in the Medical Staff by-laws. A. 27-28. The panel unanimously found that the most recent incidents "were amply supported by the record." A. 30. Concluding that Dr. Bryan's behavior was below acceptable standards and adversely impacted upon the Hospital's ability to deliver quality patient care, the panel recommended a two year suspension. A. 30-31.

On appeal by Dr. Bryan to the Hospital's Board of Directors, the Board adhered to its prior decision that any further instances of unprofessional conduct would lead to the termination of Dr. Bryan's privileges. A. 31. As reflected in the Eleventh Circuit Court's opinion:

> [T]he Hospital concluded that, because of his behavior, Bryan's presence in the operating room and in patient rooms was disruptive and interfered with the important work of other employees. Moreover, the board was properly concerned about the circumstances surrounding the misdirection of the two patients to surgery.

A. 45. Accordingly, the Board voted unanimously to terminate Dr. Bryan's clinical privileges. A. 31.

Before his staff privileges were terminated, Dr. Bryan received the full panoply of procedural protections set forth in the HCQIA. A. 44-50; *see also* A. 22-32. In the words of the Eleventh Circuit, which carefully reviewed in Part II of its opinion the peer review process at issue in this case, "each of these procedural requirements of section 11112(b) was satisfied." A. 49. Thus, Dr. Bryan was:

> (1) advised of the intended disciplinary action against him and the reasons for such action [Ex. 232, R13-158];

(2) advised of his right to request a peer review hearing and the time limit for requesting peer review [*Id.*];

(3) given timely notice of all proceedings by the Hospital related to the revocation of his staff privileges [R19-1894; Ex. 237, R23-2480];

(4) given prior notice of the procedures to be utilized at the peer review hearing, and of the witnesses who would testify against him at the hearing and the nature of their expected testimony [R15-719-20; Exs. 237-38, R23-2480-81];

(5) advised of the hearing officer and members of the peer review panel appointed by the Hospital, none of whom were in direct competition with Dr. Bryan [*Id.*], and given the opportunity to object to the proposed hearing officer and members on grounds of bias or conflict of interest, which opportunity he took advantage of [R19-1892; Ex. 237];

(6) provided with the opportunity to and did attend the peer review panel hearing with counsel of his choice [R13-20; R15-721, 726; R19-1894-95];

(7) permitted to cross examine the witnesses against him and present his own witnesses [*Id.*, R13-204-05];

(8) had the opportunity to obtain a written transcript of the proceedings before the peer review panel upon payment of reasonable charges for the preparation thereof [R17-1186-87];

(9) had the opportunity to present evidence deemed relevant by the hearing officer to the peer review panel, whether or not such evidence was admissible in a court

of law [Pl. Ex. 148, ¶ 43.6, R13-141; *See, e.g.*, Pl. Ex. 168, R13-196];

(10) given a written report containing the recommendations of the panel and a statement of the basis for the recommendations [R15-737; Pl. Ex. 401, R12-91];

(11) given notice of the Executive Committee's recommendation to the Board following peer review and notice of his right to appellate review [Ex. 245, R23-2486];

(12) provided with appellate review of the recommendation of the Executive Committee to the Board following peer review before a panel of Board Members, including the right to submit written or oral argument to the members of the appellate panel [Pl. Ex. 148, ¶ 44.1; Exs. 245-47, R23-2486, 2499-2500]; and

(13) given written notification of the Board's final decision, including a statement of the basis for the decision [R14-373; Ex. 251, R23-2503].

Following his termination from staff, Dr. Bryan sued the Hospital, the individual members of the Board of Directors, the physicians who were members of the Hospital's Medical Executive Committee, and two nurses. A. 32. The complaint included federal and state antitrust claims as well as state law claims for defamation, negligent supervision of the peer review process, and breach of the Medical Staff by-laws. *Id.*

By summary judgment order, the district court dismissed Dr. Bryan's federal and state antitrust claims for damages but held that he could assert a claim for injunctive relief under the antitrust laws. A. 34. The court also granted summary judgment on Dr. Bryan's claims against the members of the Board of Directors. *Id.* However, the court denied the Hospital's motion for summary

judgment based on the immunities provided by the HCQIA and by state law. A. 33-34.

At the close of Dr. Bryan's case, the court directed a verdict in favor of all the remaining individual defendants. A. 35. The court held that there was no evidence of any conspiracy, [R20-5-6], and noted that there had been "fifteen years of complaints" concerning Dr. Bryan's conduct, and no "nexus between those complaints and any of the defendants." R22-2003. The court further determined that none of the individual defendants was a direct economic competitor of Dr. Bryan. *Id.*; R20-5-6. The court denied the Hospital's motion for a directed verdict based upon the HCQIA. A. 35.

Under instructions and a verdict form that were objected to by the Hospital, the jury returned a verdict for Dr. Bryan, finding that the Hospital had terminated Dr. Bryan in violation of its by-laws and awarding Dr. Bryan $4,181,242, and further finding that the Hospital had violated state and federal antitrust laws. A. 35-36. The district court denied the Hospital's post-trial motions, including its motion for judgment based on the HCQIA immunity. A. 40, n.27.

The Eleventh Circuit reversed. The court specifically determined that "[t]he record in this case reveals that revocation of Bryan's privileges was prompted by the reasonable belief that doing so would promote quality health care." A. 44. It further concluded that the record established that the Hospital's action satisfied the other standards of the HCQIA. A. 45-51. The court accordingly held that the Hospital was "entitled to the immunity from damages liability granted by HCQIA in §11111(a)." A. 51. Petitioners' Suggestion for Rehearing En Banc was denied.

SUMMARY OF ARGUMENT

In holding that the Hospital could not be held liable for monetary damages for its peer review decision in this case, the Eleventh Circuit faithfully applied the immunity provision under the HCQIA in accordance with its explicit standards. Its decision presents no conflict with any decision of this Court or any other circuit court. Based on the facts of this particular case, its decision affording the Hospital HCQIA immunity was eminently correct. Accordingly, the petition for a writ of certiorari should be denied.

ARGUMENT

Petitioners ask this Court to exercise its discretion to review the Eleventh Circuit's decision on the ground that it improperly construed the HCQIA and impermissibly denied petitioners their right to a jury trial by holding that the Hospital was entitled to the immunity from liability for damages afforded under that Act. There is nothing about petitioners' challenge of the Eleventh Circuit's decision that warrants plenary review by this Court. To the contrary, that decision is carefully reasoned and based on the court's thorough consideration of the record. Moreover, it is fully consistent with the decisions of the other circuit courts that have construed and applied the HCQIA to preclude damages liability for a hospital peer review decision which complied with the standards set forth in the Act.

In short, this is a straight-forward case of statutory construction. There is no conflict among the circuits as to how the HCQIA should be applied, and there is nothing else about this case that warrants this Court's attention. Petitioners simply quarrel with the outcome of the Eleventh Circuit's application of the HCQIA's immunity to the Hospital in this case.

1. In upholding the Hospital's immunity from damages liability for its termination of Dr. Bryan's staff privileges, the Eleventh Circuit examined the statutory scheme in detail. It observed that the HCQIA was enacted because "Congress found

that "[t]he threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.'" A. 9. In an effort "to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action . . . Congress granted immunity from monetary damages to participants in properly conducted peer review proceedings while preserving causes of action for injunctive or declaratory relief for aggrieved physicians." A. 10-11.

Thus, the HCQIA provides complete immunity from damage awards for peer review actions taken "(1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts. . . ." 42 U.S.C.A. § 11112(a). The peer review action is presumed to have met those standards "unless the presumption is rebutted by a preponderance of the evidence." *Id.*

Petitioners' challenge to the Eleventh Circuit's construction and application of this statutory immunity is founded on their disagreement with the court's conclusion that "the statute's reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard."[2] A. 14-15; *see also* A. 45. This construction of the HCQIA was, however, reached by time-honored means, and it is an entirely reasonable construction.

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[2] The court also held that Dr. Bryan had, in any event, failed to establish that any personal animosity of the individual defendants "determined the outcome of the peer review process." A. 45.

The Eleventh Circuit carefully reviewed the language of the HCQIA. By its express terms, the Act does not impose any standard of "good faith" but rather requires the "reasonable belief that the action was in the furtherance of quality health care" and "the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts. . . ." §11112(a)(1), (4).

The court also reviewed the legislative history that made clear that Congress intended to adopt this objective standard rather than a subjective "good faith" standard. Thus, although a "good faith" standard was initially considered, this was abandoned in favor of a more objective "reasonable belief" standard:

> The Committee intends that *this test will be satisfied if the reviewers*, with the information available to them at the time of the professional review action, *would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.*[4]

H.R. Rep. No. 903, at 10, 99th Cong., 2d Sess. 12, reprinted in 1986 U.S.C.C.A.N. 6393 (A. 302) (cited by the Eleventh Circuit in the instant case, (A. 15, 44)) (emphasis supplied).

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[4] Petitioners also argue that the Eleventh Circuit erred in relying on this statement in the House Energy and Commerce Committee report, suggesting that subsequent amendments made the report irrelevant. That is simply not the case. No subsequent amendment changed the governing standard from the objective test back to the originally contemplated "good faith" test. The Eleventh Circuit's reliance on the Committee's statement as indicating the legislative intent with respect to the "reasonable belief" standard was completely proper.

Further, the court considered and followed the only circuit court decision that had addressed this issue at the time. In that decision, *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992), the Ninth Circuit, citing the same legislative history, expressly held that "[t]he test is an objective one, so bad faith is immaterial. The real issue is the sufficiency of the basis for the [Hospital's] actions." It is *this* language from *Austin*, *quoted* by the Eleventh Circuit at A. 45, that petitioners complain of, without disclosing that the Eleventh Circuit was simply concurring in the Ninth Circuit's construction of the Act.

Significantly, each of the circuit courts that have addressed this issue have concluded that an objective standard is to be applied in determining the reasonableness of the peer review process. *See Imperial v. Suburban Hospital Ass'n, Inc.*, 37 F.3d 1026, 1929 (4th Cir. 1994) ("the standard is an objective one which looks to the totality of the circumstances"); *Smith v. Ricks*, 31 F.3d 1478, 1485 (9th Cir. 1994) ("[T]he 'reasonableness' requirements of § 11112(a) were intended to create an objective standard, rather than a subjective standard"); *Fobbs v. Holy Cross Health Care System Corp.*, 29 F.3d 1439 (9th Cir. 1994), *aff'g* 789 F. Supp. 1034 (E.D. Cal. 1992) (Congress chose an "objective" standard for HCQIA), *cert. denied*, 63 U.S.L.W. 3559 (U.S. Jan. 23, 1995) (No. 94-994); Furthermore, although petitioners assert that the filing of opposing amicus briefs below by the American Medical Association and the American Hospital Association demonstrates the need for "guidance" from this Court on the proper interpretation of the Act, [Pet. at 14, n.14], *all* of the amici acknowledged that the Hospital's entitlement to immunity from damages must be determined on the basis of an "objective" rather than a "subjective" standard. [AMA 7-8; AHA 7-8].

In short, the Eleventh Circuit's decision comports with (1) all of the decisions of other circuits on this issue, (2) the express statutory language, which nowhere imposes a standard of subjective "good faith" but rather expressly imposes a standard of "reasonableness," and (3) the legislative history, which establishes that Congress considered a "good faith" standard but specifically

changed to a "more objective 'reasonable belief' standard." There is nothing extraordinary about the court's construction of the Act or the principles it utilized in reaching that construction. The petition is nothing more than an expression of dissatisfaction with the outcome of the Eleventh Circuit's decision in this case and presents no substantial question warranting review by this Court.

2. Petitioners further claim that the Eleventh Circuit has "created a 'new' standard to be applied in the litigation of HCQIA cases." Pet. at 20. According to petitioners, the court "has specifically ruled that the question of whether a defendant has complied with the four immunity standards of the HCQIA . . . is never a question for the jury, even if there exist genuine issues of fact." *Id.*

As shown on the face of its opinion, the court made no such ruling. Rather, the court simply held that the "*ultimate* question" of immunity from monetary liability under HCQIA is for the court to resolve, and it expressly stated that "disputed subsidiary issues of fact concerning HCQIA immunity" *are* to be submitted to the jury by way of special interrogatory. A. 39-40; *see also* A. 42. Where, however, the "evidence at trial *conclusively* demonstrates that the defendant has satisfied HCQIA standards for peer review procedures . . . then the court should grant a post-trial judgment as a matter of law under Rule 50(b)." A. 42 (emphasis supplied).

This interpretation of the Act is fully consistent with its avowed statutory purpose to remove the threat of monetary liability against those who participate in a peer review process meeting the standards set forth in the Act. That is exactly why Congress created a rebuttable presumption of immunity for such a process. The "unusual" standard that petitioners assail was established by Congress when it enacted the HCQIA, *not* by the Eleventh Circuit in the decision below.

Moreover, petitioners' contention that the Eleventh Circuit has created a "new" standard for summary judgment motions in HCQIA cases is plainly wrong. The Eleventh Circuit did nothing

more than give effect to this express statutory presumption by requiring the complaining physician to come forward with evidence establishing that the objective standards of the Act were not satisfied. A. 42. Absent such proof, judgment must be entered granting immunity from damages to the peer review participants. A. 40-42. Once again, the court's holding is completely consistent with the decisions of other circuit courts holding that such immunity should be granted as a matter of law when the standards of the Act are satisfied. *See Imperial*, 37 F.3d at 1030; *Smith*, 31 F.3d at 1485, 1487; *Fobbs*, 29 F.3d at 1443; *Austin*, 979 F.2d at 733-34.

Furthermore, contrary to petitioners' argument, this construction does not represent an improper extension of the teachings of this Court with respect to the grant of qualified immunity in Section 1983 cases. The court merely cited *Mitchell v. Forsyth*, 472 U.S. 511 (1985), for the proposition that "[i]n qualified immunity cases, the favored approach is to have the immunity determination made by the court, prior to trial, whenever possible." A. 39 n.26. Petitioners' quarrel is not with the Eleventh Circuit's reliance on the teachings of Section 1983 cases, but rather with the court's conclusion that petitioners failed to present evidence sufficient to create a genuine issue under the standards imposed under the HCQIA.

Petitioners further argue that the Eleventh Circuit's construction of this statutory presumption of immunity deprives them of their Seventh Amendment right to a jury trial. However, the mere fact that judgment must be rendered against petitioners as a matter of law, whether under Rule 50 or 56, does not implicate the Seventh Amendment. In order to create a triable issue for the jury, a plaintiff must be able to demonstrate a genuine issue of fact that is material under the applicable substantive law. The Eleventh Circuit simply found that petitioners had failed to do that and hence there was nothing for the jury to determine in *this* case.

The Eleventh Circuit's decision is fully consistent with the language of HCQIA and its intent to bolster the pre-existing

reluctance of courts to interfere with staffing decisions of governing bodies of hospitals by providing a presumed immunity from monetary damages. Petitioners' attempt to portray far-reaching ramifications of the Eleventh Circuit's decision is merely the familiar argument of a party disappointed over the outcome of an appeal.

3. Petitioners also assert that they rebutted the HCQIA presumption "as a matter of law" by presenting evidence that (a) "direct economic competitors" participated in the peer review proceedings, (b) the proceedings were conducted in "bad faith," and (c) the termination was motivated by "improper economic reasons." Pet. at 29. This contention is refuted by even the most cursory review of the record.

First of all, as petitioners concede [Pet. 28], the HCQIA only requires that the members of the hearing panel not be economic competitors of the physician being reviewed; there is no requirement that competitors avoid participation in *other* aspects of the peer review process. Here, as the Eleventh Circuit pointed out, "none of the panel members were . . . Bryan's direct economic competitors." A. 28-29 n.16. The express requirements of the HCQIA were accordingly satisfied. Moreover, even under Dr. Bryan's expanded view of the HCQIA requirements, no economic competitors participated in other parts of this peer review process. Although Dr. Bryan states that Drs. Gurri and Armstrong were his "direct economic competitors," the trial court specifically determined that they were *not* competitors of Dr. Bryan, and should accordingly be dismissed from the case, a ruling that Dr. Bryan did not challenge on appeal. R20-5-6. *See also* R15-679; R17-1370.

Second, despite petitioners' repeated references to the jury's and the district court's supposed "findings" that the Hospital acted in "bad faith," no such findings were made. A. 36. Moreover, the Eleventh Circuit specifically determined, based on its review of the record, that the hostility of certain members of the Medical Staff was *not* the cause of the Board's termination of Dr. Bryan's

staff privileges and that the Board was instead motivated by concerns for quality patient care – concerns that were raised by complaints of incidents that Dr. Bryan *acknowledged* had occurred. A. 44-45. Courts throughout the country have recognized that disruptive behavior such as Dr. Bryan's is a proper basis for disciplinary action. *See Mahmoodian v. United Hospital Center, Inc.*, 404 S.E. 2d 750, 760-61 (W. Va. 1991) (citing numerous state and federal decisions to that effect), *cert. denied*, ___ U.S. ___, 112 S. Ct. 185 (1991) (cited by the lower court at A. 51).

Third, petitioners' contention that the Hospital was improperly motivated to terminate Dr. Bryan's staff privileges because his surgeries for Medicare patients "lost money for the hospital" [Pet. 29-30] is also belied by the record. Although it is true that petitioners contended Dr. Bryan showed a loss on his Medicare patients, it was undisputed that he showed a substantial profit on his non-Medicare patients and was highly profitable for the Hospital on an *over-all* basis. Pl. Ex. 397, R17-1155. Indeed, of the Hospital's staff of some 220 doctors, he was the thirteenth or fourteenth most profitable doctor. *Id.*; R24-2664. Dr. Bryan's economic expert frankly conceded there was no economic reason for the Hospital to terminate Dr. Bryan's privileges "when you consider the total patient mix. . . ." R17-1320-21.

As can be readily seen, the petition amounts to nothing more than a request to reexamine the record and the lower court's decision in light of that record. It is not, however, the function of this Court "to grant a certiorari to review evidence and to discuss specific facts." *United States v. Johnston*, 268 U.S. 220, 227 (1925).

4. Petitioners finally urge this Court to exercise its "power of supervision" because, according to petitioners, the Eleventh Circuit "departed from the accepted and usual course of proceedings" by failing to identify the standard of review it was applying. Pet. at 31-32. The Eleventh Circuit did, however, specify the standard of review it was applying, A. 40-42, and that

standard of review is consistent with the well-settled precedent cited by the court.

In sum, the Eleventh Circuit's decision does not conflict with any decision of this Court or any other Court of Appeals. Petitioners simply disagree with the lower court's application of the HCQIA standards to the peer review proceedings afforded Dr. Bryan and its conclusion that the Hospital's peer review action complied with those standards. There is no substantial issue that warrants review by this Court of this fact-bound decision.

CONCLUSION

For the foregoing reasons, this Court should deny the petition for a writ of certiorari.

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Respectfully submitted,

Christopher K. Kay
Ronald M. Schirtzer
FOLEY & LARDNER
111 North Orange Avenue
Suite 1800
Orlando, Florida 32802-2193

and

Alan C. Sundberg
Counsel of Record
Sylvia H. Walbolt
Gary L. Sasso
CARLTON, FIELDS, WARD,
EMMANUEL, SMITH &
CUTLER, P. A.
One Progress Plaza
St. Petersburg, Florida 33701
Attorneys for Respondent